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WISCONSIN MEDICAL JOURNAL

Official Publication of the State Medical Society of Wisconsin

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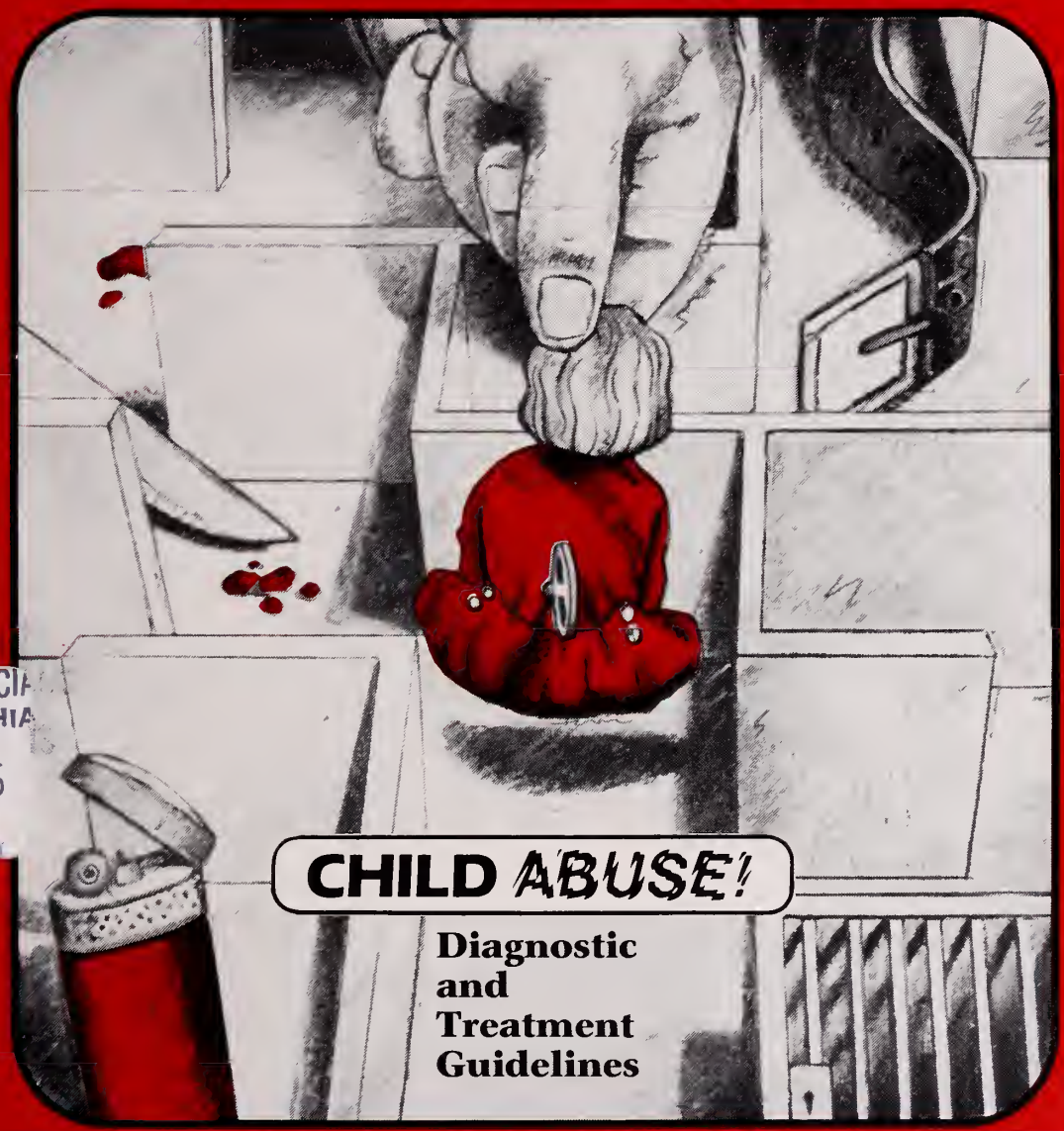

CHILD ABUSE!

Diagnostic and Treatment Guidelines

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M.D.S.

JANUARY 1985

See page 11

WISCONSIN MEDICAL JOURNAL

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CONTENTS

January 1985

SPECIAL FEATURES

4 **President's Page:** The patient is our first consideration, by *Timothy T Flaherty, MD,* Neenah

6 **Editorials:** In search of accuracy, by *Wayne J Boulanger, MD,* Milwaukee . . .-Social Security Disability Insurance Program in Wisconsin . . . Three thousand surgeries . . . Farewell . . . Elevated blood pressure, by *Victor S Falk, MD,* Edgerton

7 **Letters:** Be aware, by *Beth Foster, MD,* Wauwatosa

11 **Special:** Child abuse and neglect

16 **Special:** Documentation needs of the Social Security Administration Disability Programs, by *George H Handy, MD,* Madison

48 **Public health:** Hospital preparedness in treating radiation accident victims concerns SMS EOH Committee . . . Committee seeks ways to improve organ procurement system . . . Report on school health problems available . . . SMS leaders discuss health issues of the elderly with Coalition of Aging . . . How they handle drunk drivers in other countries

50 **Socioeconomics:** Legislative committee backs cap on attorney fees . . . DHSS proposes 3.5% increase in physician reimbursement . . . Medicare assignment sign-up reaches 36% of MDs and DOs . . . WISPAC membership shows 50% increase . . . WHCLIP rate may increase 75% . . . Health Policy Council to look at CON regs

67 Let these guides help you

68 **News you can use:** Interim recommendations issued on DPT shortage . . . Chelation therapy . . . Physicians must report child abuse and neglect

AMA Brief Reports

14 Poison-warning stickers may not work . . . Poor predictability major radial keratotomy problem . . . Cyclosporine controls herpes eye infection

20 Abdominal symptoms one sign of Rocky Mountain fever . . . Cigarettes fire-death hazard in hospital

26 Nifedipine offers rapid hypertension treatment

33 AMA book wins award . . . Linguistics offers study tool for aging

AMA News Report

30 Tissue abnormalities twice as likely for DES-exposed women

SCIENTIFIC MEDICINE

19 A case of listeriosis in Bayfield County, by *Eugenia H Parker, MD* and *Joseph B Gerwood, RN, BS,* Washburn

21 Henoch-Schoenlein purpura: Association with unusual vesicular lesions, by *Jeffrey S Garland, MD* and *Michael J Chusid, MD,* Milwaukee

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84, No. 1

CONTENTS

23 Lithium and Wisconsin—A medicinal trip through history, by *Beverly Redmann, BS* and *James W Jefferson, MD,* Madison

27 Epidemic typhus acquired in Wisconsin, by *William A Agger, MD* and *Vanee Songsiridej, MD,* La Crosse

29 COMMENTARY: Epidemic typhus in Wisconsin, by *Jeffrey P Davis, MD,* Madison

31 Is high too low? A commentary by the Wisconsin State High Blood Pressure Advisory Committee, by *Frank D Gutmann, MD,* Milwaukee

ORGANIZATIONAL

37 Highlights of AMA House of Delegates Meeting, Dec 2–5

39 Milwaukee's Weinshel named 1985 "Physician-Citizen of the Year"

40 Annual Meeting resolution deadline . . . Patient handouts available on Medicare assignment

44 Doctor Landis nominated for President-elect of SMS

44 Membership Directory—Update

52 Membership facts

54 CES FOUNDATION: Contributions for November 1984

DEPARTMENTS

10 PUBLICATION INFORMATION

53 COUNTY SOCIETIES: Milwaukee—Malpractice focus of Milwaukee county society meeting . . . Lincoln . . . Jefferson . . . Kenosha

54 PHYSICIAN BRIEFS

59 SPECIALTY SOCIETIES: Wisconsin chapter of the American College of Physicians . . . Wisconsin Chapter, American College of Physicians

59 NEWS HIGHLIGHTS

60 OBITUARIES:
Richard D Kennedy, MD
Eau Claire
Albert M Cohen, MD
Fox Point (Milwaukee)
Alphonsus M Rauch, MD
West Bend (Kenosha and Lake Geneva)
Robert B Andrew, MD
Madison
Christian Fredrik Midelfort, MD
La Crosse

61 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Announcements . . . Advertisers . . . Books received . . . Medical meetings—Continuing medical education ■

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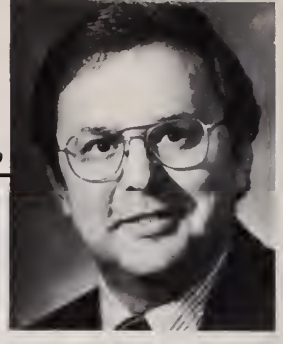
THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5600 member physicians in Wisconsin, comprising 55 county medical societies and 25 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

Timothy T Flaherty, MD



The patient is our first consideration

THERE ARE MANY who say that we have "progressed" to the point where the issue is not what's best for the patient, but how to limit access, decrease demand, and ration care. I reject that notion. The patient is, and always must be, our first consideration. If our patients cannot count on us to carry out this simple pledge, both they and we are lost.

I met just before Christmas with some forty over-65ers who make up the Board of Coalition of Wisconsin Aging Groups. Many of them realize that the federal government has broken its 1965 Medicare promises. They perceive that Medicare is paying for minimal services and not for compassion. They are scared. I don't blame them. In a sense, we physicians stand between them and a feeling of hopelessness.

Yes, there are lots of pressures to abandon the patient; lots of frustrating regulation and fudging on political promises that wear on every doctor's self-esteem and tempt us to breach ethical standards. The more we yield, the more we decrease the public's confidence in our profession.

I join AMA President Joseph Boyle, MD in his belief that we can regain the public's confidence, the patient's esteem, and our own belief in ourselves only if we accept the task of leading; making known to the public that what we do truly is on behalf of the patient.

We—SMS and SMS members—have already come quite a way:

- Two years ago we made it possible for Sharecare to provide primary medical services to 15,000 unemployed individuals and truly needy mothers and children by donating our professional services in full for ***patient care*** under this Wisconsin program, unique in the nation.
- Just two months ago we pledged to the needy of ***all*** ages that they should not go without necessary medical care for lack of money—and we're now dedicated to making that pledge work throughout Wisconsin. So far as we know, no other State Medical Society has publicly made such a commitment to ***patient care*** for the needy.
- We have a nationally recognized model program for impaired physicians—not only to rescue and rehabilitate our deserving colleagues but also primarily to carry out our obligation to assure safe and proper ***patient care.***
- We have not succumbed to FTC and antitrust pressures to limit our peer review committee's overview of the medically incompetent or aberrant practitioners. Unfortunately we have been forced as a Medical Society to cease imposing strong sanctions on such persons. And worse, the State Medical Examining Board faces several legal obstacles in its attempts to discipline the incompetent. Yet, we will continue our efforts to make this part of the system work to ***our patients'*** best interests.
- We contributed mightily to the Wisconsin Clean Indoor Air Act; we fought for and won more stringent formulas for the use of formaldehyde in mobile home construction; we have implemented better preparedness by hospitals and doctors to deal with radiation accidents in Wisconsin; we have invited a delegation of visiting Russian physicians to come and talk with us about the hazards of nuclear armaments; all of these are important to the ***care and well-being of our patients.***

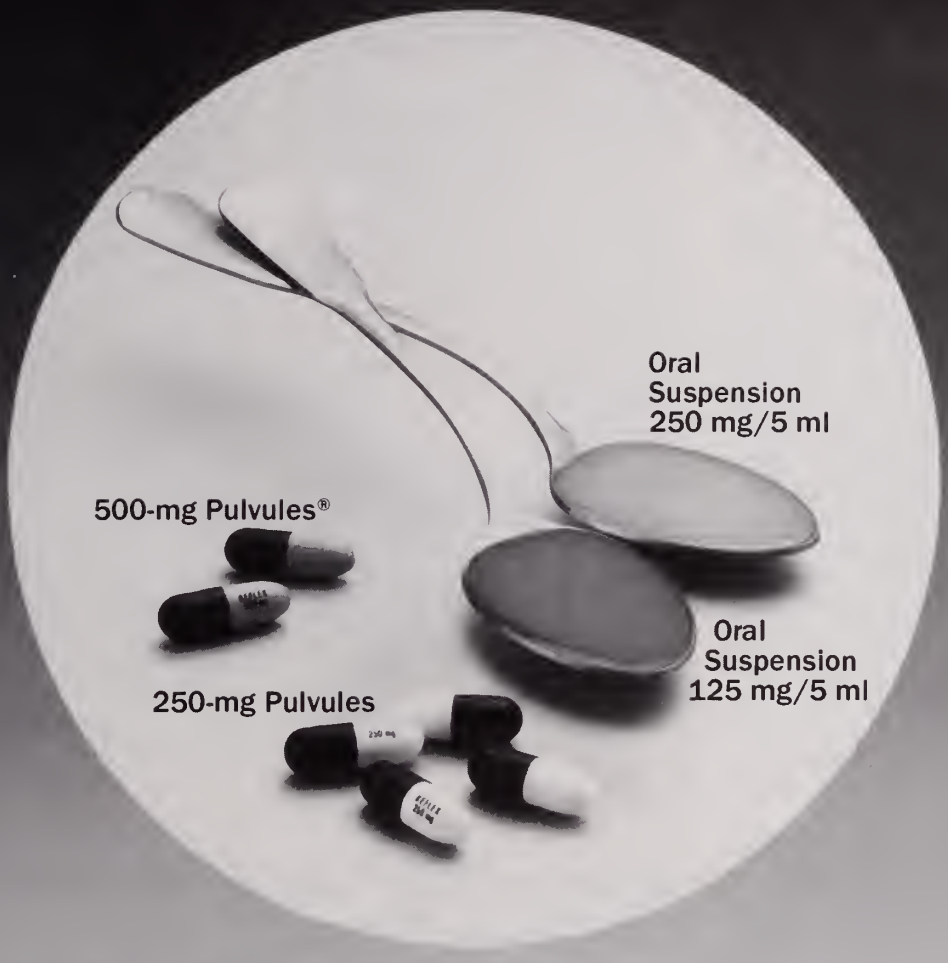
This is but part of our story; and we should tell it with pride. For my part, I intend to go on pointing out that we will help contain cost, but that limiting access or rationing care can be hazardous to your health.

I intend to go on saying that "gatekeeper" systems may sound good to the planners; they can also deprive some people of useful and necessary medical services.

I intend to go on telling the people of our state that we are interested in our patients and the kind of care they receive; that we are eager to know how they feel they are being treated by the doctors, and if they are being mistreated, we will help them.

That's what it means when we say the patient is our first consideration. What we say will have meaning only if we make it work. ■

Easy To Take



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In search of accuracy

THE WiPRO contract with HCFA continues to rankle a bit as we fall into the routine of seeking permission to arrange elective Medicare hospital admissions. But as it becomes more routine it also becomes a habit, and we'll probably soon forget this yet another freedom we have lost.

The "Quality Review Objectives" in the contract aren't as easy to forget, however. Wisconsin surgeons, (who seem to bear the brunt of the WiPRO thrust), under the leadership of the Wisconsin Chapter of the American College of Surgeons and the Council of the Wisconsin Surgical Society, have analyzed the contract for accuracy and practicality. Eventually, constructive criticism will be offered with an eye toward improving the quality of surgical practice in Wisconsin. Unfortunately, the accuracy of the data presented in the contract is by no means certain; and without accurate data, remedial actions cannot even be proven necessary, let alone planned.

At issue, of course, is the damaging statement brought out in Required Quality Objective 3A: "(To Reduce by 50% the Rate of Mortality Among Medicare Patients Electively Hospitalized and Undergoing a Class I Surgical Procedure)" "Rationale: WiPRO physicians have identified an incidence of potentially avoidable mortalities among Medicare patients electively undergoing a Class I surgical procedure. The combined data bases of WisPRO and FMCE suggest that 291 of 1332 deaths within this patient group were potentially untimely or premature." That amounts to an avoidable death rate of 22 percent! If it is correct, then remedial action is indeed necessary.

However, it is our understanding that the 291 avoidable deaths' figure was not developed through individual case studies, but is merely an estimate based on what may be erroneous premises. If that is true, then Wisconsin surgery has been delivered a low blow by people who should know better.

Our course is clear. The 1332 deaths must be scrutinized individually if an accurate "avoidable death" incidence for that group is to be determined. The Wisconsin Chapter of the American College of Surgeons and the Wisconsin Surgical Society have offered to do this. Perhaps by the time this goes to press, the review will already be under way.

—*Wayne J Boulanger, MD,* Milwaukee

Editorial Board comment: *Doctor Boulanger shows commendable restraint, for they have planned to desecrate the sanctuary of those who seek care and to pollute the dwelling place of those who provide it. We agree there is a glaring absence of verifiable information re quality of care issues, and that far-reaching decisions are being made on the basis of hopelessly inadequate data. For example, one of the prized "facts" indicting medical practice standards in this country is the variation found in length of stay in different parts of the country. Yet in an important study reported in the November 1984 issue of* Medical Care, *substantial regional differences in LOS all but disappeared when socioeconomic conditions (*ie, *entirely nonmedically determined factors) were taken into account. Doctor Boulanger is absolutely correct in pointing out the need for having credible data before massive efforts are mobilized to correct minor or even nonexisting problems. Why forget Don Quixote in these times?*

Social Security Disability Insurance Program in Wisconsin

IN THIS ISSUE is an important article by Dr George Handy, formerly State Health Officer and now Chief Medical Consultant for the State Bureau of Social Security Disability Insurance. His office processes about 900 applications for disability each week. Eventually about 40% are allowed.

Doctor Handy emphasizes the necessity of submitting detailed information beginning with the date of onset. A common misunderstanding for both patients and physicians pertains to the definition of disability—in this situation it is the inability to engage in *any* substantial gainful activity.

Since the ultimate determination is based on evidence from medical sources, physicians must submit accurate, detailed reports if they are to be of help to their patients. This is becoming more important with our increasing aging population and with such militant, potent organizations as the American Association of Retired Persons turning on the heat in Washington.

—*Victor S Falk, MD,* Edgerton

Three thousand surgeries

MEDICAL MARKETING is now a way of life, but the high-priced hucksters would do well to seek medical advice as well as a basic course in the English language. Recently we have been informed repeatedly by a wide-ranging commercial aired from a Chicago radio station that the Chicago area hospitals of a religious group have performed "3,000 orthopedic surgeries" in the past year.

First of all, it is obvious that the hospitals did not perform any operations. In addition the usual concept of a surgery is that it is the site where surgical procedures are carried out.

It's a small matter, but if we have to be assailed with this type of salesmanship, the medical marketors should tidy up their act.

—*Victor S Falk, MD,* Edgerton

Farewell

SINCE NOVEMBER 1949, the bottom half of the cover of the *Wisconsin Medical Journal* has presented an ad from Eli Lilly & Co. Over the years this has been an important source of income, but it also has been a point of criticism by journalism experts during critique sessions at the annual medical journal conferences. We have appreciated the revenue but not the barbs. We are one of the very last journals to drop the front cover advertisement. The last ad appeared on our December 1984 issue. In bidding farewell to the front cover Lilly ad, the *Journal* wishes to thank the Lilly company for its continuous support of more than three decades.

We do not plan to present works of art on the cover in competition with *JAMA*. However, we may occasionally exhibit the picture of a new society president, the honoree of a *festschrift,* or some theme appropriate to a special issue.

In any event, we will maintain our color scheme and will still be referred to as the "red journal."

—*Victor S Falk, MD,* Edgerton

Elevated blood pressure

IN THIS ISSUE of the *Wisconsin Medical Journal* there appears a commentary by the Wisconsin State High Blood Pressure Advisory Committee. This is a sequel to an article published exactly five years ago. The Advisory Committee has made changes in the guidelines for use at screening sites, and it is essential that Wisconsin physicians familiarize themselves with the new criteria.

It is anticipated that there will be an increase in referrals to physicians. Also there may be differences in opinions relative to the program, and comments are welcome.

—*Victor S Falk, MD,* Edgerton ■

LETTERS

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Be aware

TO THE EDITOR: My congratulations to Doctor Schoenwetter for his very nice article (*WMJ:* November 1984) regarding the "gray area" child.

He points out some very important and relevant issues for the physician who is helping a family in meeting their child's educational needs.

The law protecting the educational needs of the moderately and severely involved child meet their needs very well. It is unfortunate how many children "fall between the cracks" in the public educational system.

The message to the practicing physician is clear. An M-team cannot be used as an educational, psychological, and speech evaluation.

When families come to us with a concern about school failure, we need to be aware of what our community can offer in terms of testing and rehabilitative and educational support for these children.

—*Beth Foster, MD*
Pediatrician
9001 Watertown Plank Road
Wauwatosa, Wisconsin 53226 ■

PSYCHIATRIST
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(sī-kī-ə-trĭst, sī)

Psychiatrist. Look it up in a dictionary and you will likely find definitions that speak of a doctor whose practice pertains to working with patients afflicted with mental, emotional, and behavioral disorders. And that's true . . . as far as it goes.

At Milwaukee's St. Mary's Hill Hospital, we believe some elaboration is necessary . . .

"PSYCHIATRIST: 1) a fully trained and experienced physician engaged in the practice of psychiatry; 2) one who understands that when you make a referral for psychiatric treatment, you should be kept informed of and involved in your patient's care; 3) the medical professional who has the primary responsibility for treating patients at St. Mary's Hill Hospital."

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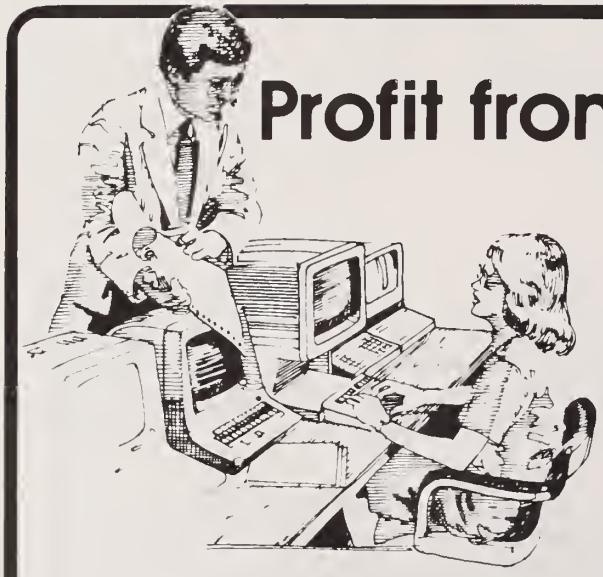

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Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

Winthrop-Breon

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Please see following page for Brief Summary.

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TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions. Usage with Alcohol.* See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility.* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C.* Should be given to pregnant women only if clearly needed. *Labor and Delivery.* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular.* Hypotension, tachycardia, syncope. *Respiratory.* Rarely, respiratory depression. *CNS Acute CNS Manifestations.* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal.* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic.* Edema of the face; dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other.* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

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Child abuse and neglect

a•buse (a-byoos)n. 1. a misuse. 2. an unjust or corrupt practice. 3. abusive words, insults. abuse (a-byooz) v. (a•bused, a•bus•ing) 1. to make a bad or wrong use of, *abuse one's authority.* 2. to treat badly. 3. to attack in words, to utter insults to or about.

[*Oxford American Dictionary,* Oxford University Press, Inc 1980, p 6]

Front cover artwork courtesy of *Iowa Medicine*

THE NEW LAW relating to reporting of child abuse and neglect (1983 Wisconsin Act 172) (*Wisconsin Statutes* 48.981) has created concern, not to mention controversy, within the medical, social services, and enforcement communities.

The Act changed the reporting and investigation of child abuse and neglect cases in this state by:

(1) Expanding the list of persons required to *report* suspected abuse or neglect;

(2) Expanding the definition of child abuse to include *sexual exploitation* of children and *emotional damage* to children;

(3) Eliminating some of the procedural requirements applicable to reporting and documentation of specific incidents of abuse or neglect and determining the guilt or innocence of persons suspected of child abuse or neglect; and

(4) Establishing new procedures for providing services to children and families where child abuse or neglect has occurred or is threatened.

Individuals whose employment brings them into regular contact with children are *required* by law to immediately report suspected abuse or neglect. Included as mandated reporters under Wisconsin law are:

- physicians
- coroners
- medical examiners
- nurses
- dentists
- chiropractors
- optometrists
- law enforcement officers
- other medical and mental health professionals
- social workers
- public assistance workers
- child care workers
- school teachers, counselors, and administrators.

Under the current Act, any person who wilfully fails to file a required report carries a penalty of a fine not more than $100 or imprisonment for not more than six months, or both, to a fine of not more than $1000 or imprisonment for not more than six months, or both.

Any person or institution participating in good faith in reporting suspected cases of abuse or neglect is immune from any liability, civil or criminal, that results by reason of the action.

In 1981, 1482 Wisconsin children were positively determined to be abused or neglected, and in eight of these cases, the children died. In 1982, 1754 Wisconsin children (up 1.9 percent over the previous year) were determined to be abused or neglected; of this number, nine died. Reported cases of child abuse and neglect have increased 13 percent in the past four years.

Child sexual abuse, a highly complex problem, during the same period, has emerged as the most rapidly increasing type of reported abuse. Reports from 1979 showed 318 reports and rising to 1471 in 1982. Between 1981 and 1982, the reports of child sexual abuse increased 21 percent.

The American Medical Association has made child abuse and neglect a top priority. A report of the AMA Council on Scientific Affairs entitled "Diagnostic and Treatment Guidelines for Child Abuse and Neglect" reflects the views of scientific experts and reports in the scientific literature as of December 1984.

Hopefully, these guidelines will help physicians improve their child abuse diagnostic and treatment skills. A complete copy of the *Guidelines* is available upon request to the SMS.

[This report is not intended to be construed as a standard of medical care. Standards of medical care are determined on the basis of all of the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve.]

INTRODUCTION. Every year, more than a million children in the United States are seriously abused by their parents, guardians, or others, and between 2000 and 5000 children die as a result of their injuries. Although child

abuse may have been identified as a social problem in the last century, it took almost 100 years for violence toward children to be considered a major national problem.

In the 1940s, through the use of diagnostic x-ray technology, physicians began to notice in young children patterns of healed fractures that could have resulted only from repeated blows. It was not until C Henry Kempe and his associates published "The Battered Child Syndrome" in the *Journal of the American Medical Association* in 1962, that battering and abuse became a focal point of public attention. By the end of the 1960s, all 50 states had passed laws requiring the reporting of child abuse and neglect and had initiated efforts to treat abused children and their families.

Facts about child abuse and neglect. Child maltreatment is serious and life-threatening, a phenomenon that affects not only children but also families and society. The causes of abuse and neglect are complex and variable, but it is most useful to understand that they may be symptoms of a dysfunctional family.

Correlations between child maltreatment and family characteristics that have been identified include some of the following:

Families who are or have:
- low-income;
- socially isolated;
- where husbands and wives resort to violence to one another;
- where parental expectations are inconsistent with the child's developmental abilities;
- stressors such as alcohol and drug misuse.

Children who are or have:
- premature birth;
- adolescent parents;
- congenital deficiencies.

The etiology of child abuse and neglect is an interactional one. The primary care physician must take into account social, familial, psychological, and physical factors in developing a treatment plan for the abused or neglected child.

DIAGNOSIS. A complete physical examination, including developmental testing, on any child who may be a victim of abuse, must be conducted. Laboratory studies are useful in delineating the nature and extent of current trauma and in defining the presence of previous trauma.

The physician should also:
- understand and assess the plausibility of historical and medical antecedents;
- determine the dimensions of continued risk;
- obtain the medical history.

Signs of physical abuse. It is estimated that more than 125,000 new cases of physical abuse occur annually in the United States. Nonaccidental trauma is the most easily identified type of abuse and most commonly seen by physicians. Characteristically, the injuries are more severe than those that could reasonably be attributed to the claimed cause.

Physical signs:
- bruises and welts;
- burns;
- fractures;
- lacerations or abrasions;
- abdominal injuries;
- central nervous system injuries.

Behavioral signs: The abused child is likely to have behavioral problems. The following signs may be seen as either provoking or resulting from abuse:

The child may:
- be less compliant than average;
- exhibit signs of negativism;
- appear to be unhappy;
- be angry, isolated, destructive;
- display abusive behavior toward others;
- have difficulty developing relationships;
- display either excessive or complete absence of anxiety about separation from parents;
- display inappropriate caretaking behavior toward parents;
- constantly be in search of attention, favors, etc;
- evidence a variety of developmental displays.

Signs of physical neglect. Physical neglect appears to be more common than physical abuse. Neglect tends to be chronic in nature and is defined as the failure of a parent or other person legally responsible for a child's welfare to provide for the child's basic needs and an adequate level of care.

Physical signs:
- malnutrition;
- repeated episodes of pica;
- constant fatigue or listlessness;
- poor hygiene;
- inadequate clothing for circumstances.

Behavioral signs:
- lack of appropriate adult supervision;
- repeated ingestions of harmful substances;
- poor school attendance;
- exploitation;
- "role reversal;"
- drug or alcohol use.

Signs of medical neglect:
- failure to receive adequate medical attention;
  - —absence of necessary immunizations and medications;
  - —absence of dental care;
  - —absence of necessary prosthetics including eyeglasses, hearing aids, etc.

Signs of sexual abuse. Child sexual abuse is the exploitation of a child for the gratification or profit of an adult. It can range from exhibitionism to intercourse or use of a child in the production of pornographic materials. Sexual abuse generally is perpetrated by someone known to the child and frequently continues over a prolonged period. The incidence is estimated at 100,000 to 250,000 cases per year; however, this type of abuse is difficult to detect and confirm.

Physical signs:
- difficulty in walking or sitting;
- thickening and/or hyperpigmentation of labial skin (especially when it resolves during out-of-home placement);
- horizontal diameter of vaginal opening that exceeds 4 mm in prepubescent girls;
- torn, stained, or bloody underclothing;
- bruises or bleeding of the genitalia, perineum or perianal area;
- vaginal discharge and/or pruritis;
- recurrent urinary tract infections;
- gonococcal infection;
- syphilis;
- genital herpes;
- trichomonas;
- chlamydial infection when present beyond first six months of life;
- lymphogranuloma venereum;
- nonspecific vaginitis;
- candidiasis;
- pregnancy;
- sperm or acid phosphatase on body or clothes; sperm in the urine of female child;
- lax rectal tone.

Behavioral signs: These are dependent upon the age of the child, emotional maturity, nature of the incident, duration of sexual abuse, and the child's relationship to the offender.

The child may:
- confide in a relative, friend, or teacher; the disclosure may be either overt or subtle and indirect;
- become withdrawn and daydream excessively;
- evidence poor self-esteem;
- appear frightened or phobic, especially of adults;
- experience distortion of body image;
- express general feelings of guilt or shame;
- exhibit a sudden deterioration in academic performance;
- show pseudomature personality development toward offender;
- display regressive behavior;
- attempt suicide;
- exhibit a positive relationship toward offender;
- display eneresis and/or encopresis;
- engage in excessive masturbation;
- engage in highly sexualized play;
- become sexually promiscuous;
- have a sexually abused sibling.

Signs of emotional maltreatment. Parents or caretakers who maltreat children emotionally are frequently unable or unwilling to provide the emotional attention and nurturance necessary for normal growth and development.

Physical signs:
- delay in physical development;
- failure to thrive.

Behavioral signs: The child may exhibit:
- distinct emotional symptoms and/or functional limitations that can be causally linked to parental management;
- deteriorating conduct;
- increased anxiety;
- apathy or depression;
- developmental lags.

[The *Guidelines* enumerate do's and don'ts pertaining to the interviewing process relating both to children and parents, and will not be listed here.]

MANAGEMENT OBJECTIVES. Major management objectives for the physician include the following:
- identify the child;
- take emergency measures needed to prevent further injury;
- provide medical evaluation and treatment;
- provide an accurate and complete medical evaluation with documentation to include:
  - —brief description of the nature and extent of the injuries and medical condition of the child;
  - —all relevant behavior and statements;
  - —complete medical and brief social history;
  - —results of all laboratory and diagnostic procedures;
  - —color photographs and x-rays if applicable.
- remain objective and nonjudgmental;
- attempt to establish or maintain a therapeutic alliance with the family;
- attempt to secure medical evaluation of other children in the household;
- report all suspected cases.

REPORTING REQUIREMENTS. Although child abuse and neglect laws vary among jurisdictions, all statutes include:
(1) quick identification,
(2) designation of an agency, and
(3) provision for treatment services.

In its February issue, *The Child Abuse Law-Explanation and Implications* will be published by the *Wisconsin Medical Journal.* The report will address what the law

requires; potential resolutions of legal problems and requirements, along with formal and informal guidelines.

TRENDS IN TREATMENT AND PREVENTION. The physician's role in the treatment of child abuse and neglect historically has been one of detection, medical diagnosis, and treatment or referral. Physicians can now participate in the primary prevention as well as work with local child protection agencies to develop a followup mechanism for reported cases. Comprehensive prevention strategies should attempt to reduce the burden of child care, family isolation, and long-term consequences of poor parenting. Increased access to health and social services for all family members is another goal of any prevention effort.

Future *WMJ* articles will detail what happens once the report is made and the aftermath—dealing with the victim and family back in the community setting.

—Prepared by *Deb Powers,* Policy Analyst, SMS Physicians Alliance Division ■

AMA Brief Reports

Poison-warning stickers may not work

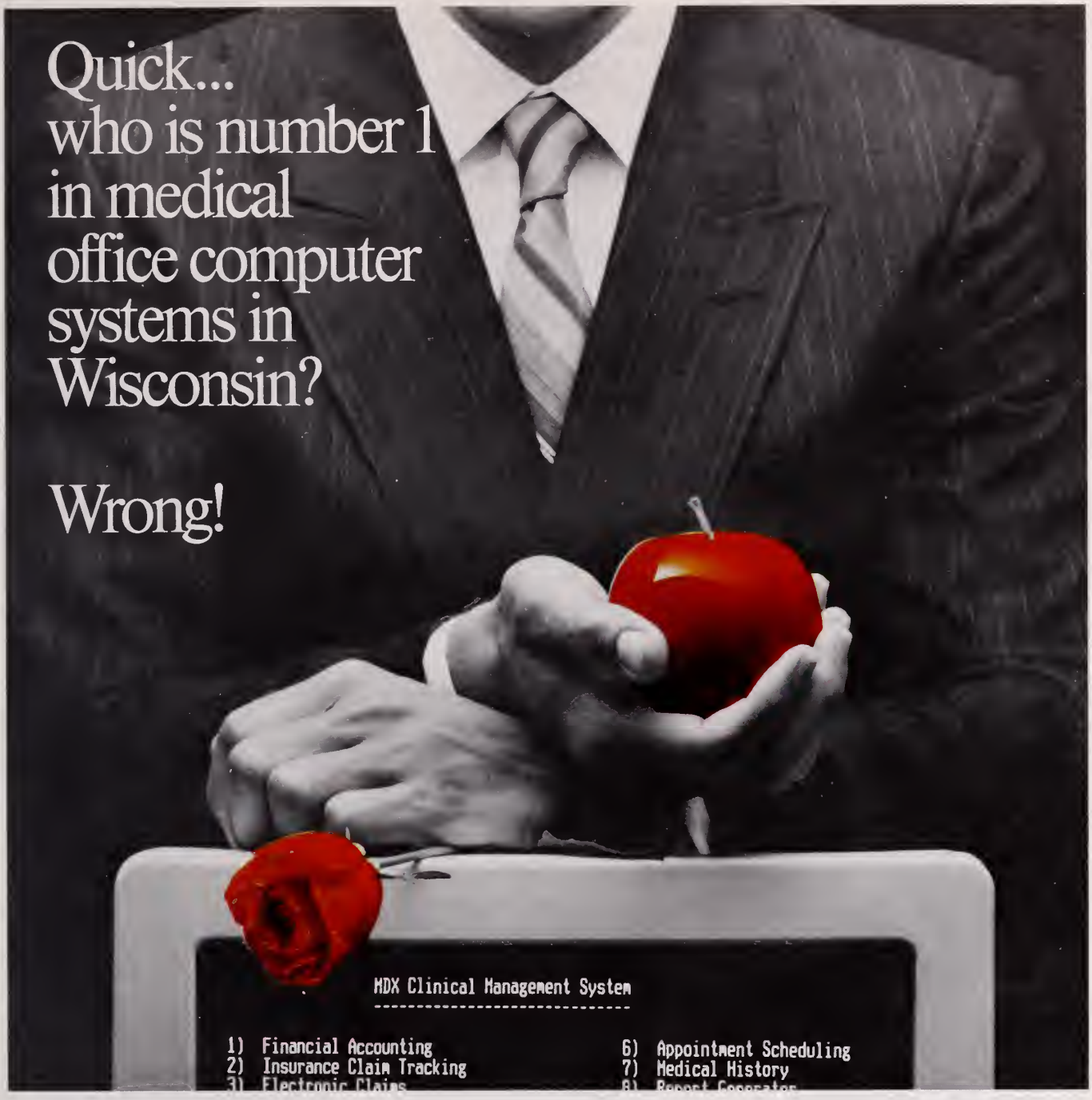
Toddlers may not be deterred from manipulating containers that are labeled with poison-warning (Mr Yuk) stickers, according to Katherine Vernberg, MPH, and colleagues from the University of Virginia School of Medicine in Charlottesville. They examined the behavior of 20 children ages 12 to 30 months before and after education on labeling and poison. Before instruction, toddlers played with labeled and unlabeled containers without statistical preference. After instruction, they showed a touch preference for the poison-warning labeled containers. The report appears in the November 1984 *American Journal of Diseases of Children.* ■

Poor predictability major radial keratotomy problem

Poor predictability with variable results is the major problem with radial keratotomy today, says Perry S Binder, MD, of La Jolla, Calif, in the November 1984 *Archives of Ophthalmology.* He says the National Eye Institute has now completed the second year of its multicenter study of the procedure and that expertise is growing. "The procedure is capable of correcting approximately 4 to 5 diopters of myopia," he says. "Ophthalmologists must discuss the variability of the procedure with their patients, explain the potential and reported complications, and present the alternatives of continuous or daily wear contact lenses." ■

Cyclosporine controls herpes eye infection

Using experimental animal models, Helene M Boisjoly, MD of Harvard Medical School, and colleagues demonstrated significant decrease in herpetic stromal keratitis (inflammation of the cornea caused by herpes simplex virus) by applying a 1% solution of cyclosporine to the affected eye. Such infections now are treated with topical corticosteroids, which may be associated with several corneal complications, the researchers say. "Our finding of a beneficial prophylactic effect of topical cyclosporine in experimental herpetic stromal keratitis (HSK) opens new possibilities for the treatment of HSK," they say in the December 1984 *Archives of Ophthalmology.* Cyclosporine is a powerful immunosuppressant drug. ■



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Documentation needs of the Social Security Administration Disability Programs

George H Handy, MD, Madison, Wisconsin

THE SOCIAL SECURITY Disability Program is undergoing changes in terms of policy and eligibility criteria at the federal level. This program has been with us since 1935, and it affects all citizens. The system may change, but its application must be fair and equitable to all. In Wisconsin this has been the goal, and the method has been the informed involvement of the medical system.

In the United States nearly 5 million disabled persons are receiving cash benefits each month. In Fiscal Year 1983, the Social Security Administration (SSA) processed over 1.25 million claims. Over $22 billion in actual cash benefits are paid to disabled persons and their families under the Social Security Disability Program and Supplemental Security Income Program. Also, in FY 1983, SSA paid out over $200 million for medical evidence, including $175 million for consultative examinations. The Administration has over 1200 physicians on duty (part-time and full-time) in the Disability Determination service.

In Wisconsin, the Bureau of Social Security Disability Insurance receives about 900 applications a week from Wisconsin citizens. These have been screened by the local Social Security agencies for nonmedical eligibility. Of this number about 15% are for review of previously allowed disability claims. The remainder are new or appealed claims.

Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable mental or physical impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.

The determination ***must*** be based on evidence from medical sources.

About half of the cases are reviewed and adjudicated from evidence from treating physicians' records and records from hospitals, clinics, sanitoriums, mental institutions, or other healthcare facilities. The remaining cases require consultative examinations which, in Wisconsin, are physical examinations purchased from practicing physicians on a fixed-fee basis.

A panel of about 1800 physicians who are willing to schedule and examine these claimants has been established. This panel includes licensed physicians, licensed osteopaths, licensed or certified psychologists, and licensed optometrists for measurement of visual acuity and visual fields. Some states depend primarily on key provider groups who only supply services to SSA for the examinations. The consultative examinations put about $250,000 monthly into the medical economy of Wisconsin.

The medical evidence obtained, whether from records or examinations, must be of sufficient detail in documentation so that a physician who has never seen the claimant can make an independent evaluation, based on objective findings, to determine the nature of the claimant's medical condition and also rate the severity of the impairment as the residual functional capacity. The medical evidence must detail the symptoms, signs, and laboratory findings which indicate that a claimant has a medical condition which limits the ability to work.

The standards for the disability evaluation are listed in "A Handbook For Physicians" which is available and is supplied to all examining physicians. Many of these standards are being revised and updated.

If a person has only one impairment and the medical evidence documents no others, all pertinent information concerning that impairment must be supplied. For example, if the claimant has a condition involving the musculoskeletal system, the pertinent information could include medical and surgical notes describing range of motion and functional restrictions, initial and subsequent x-ray reports, laboratory reports, operative procedure reports, physiotherapy reports showing range of motion in degrees, and even electromyograms and nerve conduction study results.

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Sometimes a claimant believes that he or she is disabled only in one body system, and the SSA only requests information related to that one body system. However, unknown to the claimant and the SSA, medical evidence may exist which points to other serious impairments of one or more body systems. The SSA relies on local treating physicians to help discover this information. It is critical that all the additional medical material be included in the reports, because it may make the difference between allowing or denying the claim.

In one example, a claim for benefits was filed for a heart condition which was not severe, but the medical reports show that the person was also missing both legs and used prostheses. This impairment was not reported, because it had occurred at a young age and the claimant had adjusted to it. Without the complete medical reports in this case, the SSA would have denied the claim. With them, an allowance was made immediately.

Multiple alleged impairments must all be documented regardless of the basis.

Many people in hospitals' and doctors' offices who send records may believe that the SSA only requires the latest information from the records; that is, the hospital discharge summary. ***This is not necessarily true.*** One of the biggest problems is deciding the date on which the claimant became disabled, or the "onset" date. This is the date upon which the claimant's impairment or combination of impairments became sufficiently disabling to prevent work and the basis for onset of payment and may allow retroactive payments. Sometimes this is clear-cut, as in the case of a traumatic event such as a motorcycle accident. But with long-standing impairments, often with multiple hospital admissions or repeated physician visits, it is important to review admission records, intermediate records, findings in the discharge summary in order to pinpoint the onset date.

The continuous medical record has another valuable purpose. The onset date and current condition may be known, but what about the months and years in between? In order to grant the claimant a continuous period of disability, SSA must know what happened in the period between onset and the present time. This is particularly important in documenting the history of individuals with mental impairments, but it is important for physical conditions as well.

In 1980, Congress directed the SSA to review the claims of all disabled persons at least once every three years or less often if the impairment is permanent. The medical evidence forms a basis for any decision as to whether the beneficiaries continue to receive benefits. Local treating physicians can help the Social Security Adjudicator make the correct decision in every case by providing copies of all medical evidence. Also, it is important that all copies of medical records be as legible as possible. It is equally important that the copy be complete. It is sometimes very difficult to determine whether a page was missing from a lengthy medical report, and the missing page may contain evidence that makes a difference between an allowance and a denial of the claim.

The importance of accurate and complete information cannot be over emphasized. The SSA decision-making process is rendered helpless without it. The work of local treating physicians in supplying all pertinent medical records is instrumental in making fair, uniform, correct, and equitable disability determinations. It is of the utmost importance to millions of individuals who file applications for disability benefits. The continued prompt and thorough response to SSA information requests is what makes the system work, and work fairly.

The Bureau of Social Security Disability Insurance is constantly attempting to add consultative examiners to the panel. This is particularly true in the outlying and northern parts of the state which have a very small number of specialists to perform the examinations in the fields of orthopedics, neurology, and ophthalmology.

There also is opportunity for physicians to be employed in the Central Office in Madison to review and provide expert advice to the lay adjudicators who are responsible for the determinations of disability and to call local treating physicians for additional medical information.

If the Bureau can supply any additional information, please call George H Handy, MD, Chief Medical Consultant, Bureau of Social Security Disability Insurance, Box 7623, Madison, Wis 53707; telephone (608) 266-6608. ■

A voice of one whispers... A voice of many influences.

Physicians and their spouses concerned with the future of medicine in Wisconsin make up the strong, influential political voice called WISPAC.

Their individual participation has brought a high degree of success to the efforts of WISPAC. In the last several election cycles alone, over eighty percent of the candidates for political office chosen to receive financial and technical support were elected, thus strengthening medicine's position in the legislative forum.

Physicians control WISPAC—responsible physicians like yourself; physicians who realize that their political involvement at the local level, and their support of WISPAC through membership and financial contribution, is essential to continuing the influential political voice of medicine in Wisconsin.

In 1984 WISPAC membership reached an all-time high, but much more needs to be done, beginning today, to ensure success in the future.

Political action must not end with the elections. The 1985 legislative session begins in January and promises to be most challenging. WISPAC will continue to play an important role during the session coordinating fundraising efforts, other local political activities, and most importantly, physician-legislator contacts.

In order to be effective, WISPAC needs your voice, and your support. Join with those who realize that medicine is a constituency. Join WISPAC!

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A case of listeriosis in Bayfield County

Eugenia H Parker, MD and *Joseph B Gerwood, RN, BS*
Washburn, Wisconsin

ABSTRACT. *While still considered an uncommon disease,* Listeria monocytogenes *infections are becoming more prevalent in humans. This report details the course of a previously healthy, elderly woman from Washburn, in northern Bayfield County, Wisconsin, who contracted Listeria infection. Although few data are available, listeriosis is a rare condition at both Bayfield County Memorial Hospital in Washburn and Memorial Medical Center in Ashland.*

KEY WORDS: Listeriosis, *Listeria monocytogenes,* Listeria meningitis

LISTERIA MONOCYTOGENES infections are increasing in occurrence, and in adults the form the disease takes is usually meningitis.[1] Both man and animal can contract listeriosis and most humans are usually exposed to this Gram-positive rod sometime, but if a person is immunocompromised, this generally mild pathogen can be fatal.[2] However, even healthy people may succumb to this illness.[3] If patients are to survive, it is vitally important that early diagnosis and treatment be instituted.[2] Besides those who are immunocompromised, listeriosis mainly affects newborns, pregnant women, and the elderly.[4]

CASE REPORT. A 77-year-old lady was admitted to the hospital with complaints of fever, chills, periorbital headache, vague abdominal tenderness, and generalized aching. Also, she had been dizzy, short of breath with a dry cough, and had had a syncopal spell in her bathtub the previous night. Her medical history was basically negative except for essential hypertension under control with hydrochlorothiazide. The admitting diagnosis was cephalgia with questionable syncopal episode, presenting as probably a viral illness.

On admission she was acutely ill. Her pupils were equal and reactive to light and accommodation. There was some discomfort on neck flexion but no nuchal rigidity. The heart and lungs were normal. Mild abdominal tenderness on palpation was apparent as was general tenderness of the musculature of her extremities and unsteadiness on her feet. Blood pressure was 110/60 mm Hg, pulse rate 82, respirations 16, and oral temperature 38.9 C, rising later on the day of admission to 39.4 C.

Initial laboratory evaluation was essentially negative except for elevation of the blood sedimentation rate at 37 mm/hr and slight elevation of the white blood cell count, 13,400 per cu mm. The differential leukocyte count was 66% segmented neutrophils, 17% stab forms, 10% lymphocytes, 6% monocytes, and 1% eosinophils. A repeat white blood cell count on the third hospital day was 8600 per cu mm with 61% segmented neutrophils and 4% stab forms. On the sixth hospital day the white blood cell count was 11,700 per cu mm with 66% segmented neutrophils and 12% stab forms.

The patient followed a febrile course, temperature rising to 38.3 C to 38.9 C daily, and continued to complain of dizziness, chills, and headache. On the sixth hospital day a blood culture was obtained; this subsequently showed no growth. On the seventh hospital day a spinal tap was performed, yielding cerebrospinal fluid which appeared clear but had a cell count of 308 per cu mm, 70% of the cells neutrophils. The spinal fluid protein was elevated at 165 mg/100 ml, the sugar depressed at 32 mg/100 ml. The cerebrospinal fluid culture grew *L. monocytogenes.*

The day following lumbar puncture the patient was started on chloramphenicol sodium succinate 750 mg intravenously every six hours and ampicillin sodium 1.5 Gm intravenously every six hours. When the cerebrospinal fluid culture was reported, chloramphenicol was discontinued and ampicillin increased to 1.0 Gm intravenously every two hours. She continued on this treatment for 15 days. At discharge she was afebrile and felt well, ambulating without difficulty. There were no neurologic deficits. A followup clinic visit was uneventful.

DISCUSSION. Human infections with Listeria usually show a polymorphonuclear response in peripheral blood, cerebrospinal fluid, and tissues.[5] The patient des-

Doctor Parker is hospital pathologist and both Doctor Parker and Mr Gerwood are members of the Infection Control Committee. Reprint requests to: Joseph B Gerwood, RN, Route 1, Box 19-A3, Washburn, Wis 54891 (phone: 715/373-2904).
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cribed in this article is typical. The polymorphonuclear leukocytes (PMNs) in her blood were slightly high but the cerebrospinal fluid showed a marked elevation of the PMNs. Nieman and Lorber[1] report in their review of the literature that an underlying malignancy occurred in 25% of patients, that meningitis was present in 30% of apparently healthy individuals and that fever was reported in almost all cases. Our lady had no malignancy and was healthy for her age. She was febrile during much of her hospitalization.

Nieman and Lorber's report covered 186 cases of adult listeriosis collected from the medical literature between 1968 and 1978. They found that 55% of these patients had listeria meningitis. Fever was an important finding in all cases and the cerebrospinal fluid showed the typical features of bacterial meningitis, as in the presently reported patient. Blood cultures were positive for *L. monocytogenes* in 75% of the cases. The overall mortality rate among these meningitis cases was 30%. Better survivals occurred, however, among patients who had no serious underlying disorder, such as malignancy or immunosuppression.

In the 102 cases of Listeria meningitis reviewed in this article, 60% of the patients had malignancy and an additional 28% were receiving corticosteroids or other immunosuppressive therapy. Another 21% had a variety of significant chronic diseases, including sarcoidosis, alcoholism, diabetes, cirrhosis, and splenectomy. Only 13% of the meningitis patients had no known underlying disease. The present patient falls into that minority of cases.

The initial bacteriologic diagnosis of *L. monocytogenes* at the Bayfield County Memorial Hospital laboratory was subsequently confirmed by the State Laboratory of Hygiene in Madison. The State Laboratory reports that it identified seven cases of Listeria infection in 1983, two in 1982, and ten in 1981. These data probably underestimate the number of cases in Wisconsin, since some laboratories may not submit Listeria isolates to the state facility for confirmation.

The present patient is the only case of Listeria meningitis seen in the past ten years at either Bayfield County Memorial Hospital in Washburn or at Memorial Medical Center in Ashland.

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AMA Brief Reports

Abdominal symptoms one sign of Rocky Mountain fever

The rash associated with Rocky Mountain spotted fever (RMSF) usually appears between the second and fifth day of the sometimes fatal (3% to 10% of patients) illness, but abdominal symptoms often appear earlier and should be recognized, write Milton B Randall, MD and David H Walker, MD in the December 1984 *Archives of Pathology and Laboratory Medicine*. Their autopsies of 28 fatal cases showed that 91% had rickettsial lesions in tissue from the pancreas, stomach, small intestine and colon. In these cases, severe abdominal symptoms were noted in 72% of the patients, but were not associated with the spotted fever. "To reduce the mortality of RMSF, these clinical manifestations must achieve wider recognition," say the researchers, from the University of North Carolina School of Medicine in Chapel Hill. ■

Cigarettes fire-death hazard in hospital

Five of eight patients burned in hospital fires started by cigarettes died, according to a report in the Letters section of the November 23, 1984 *Journal of the American Medical Association*. "Their mortality is almost five times greater than that for community-acquired flame burns (started from cigarettes)," say Frederic S Bongard, MD, and associates from the University of California, San Francisco. Fires in both homes and hospitals occur when cigarettes fall into bedding, but hospital patients are less able to respond appropriately, the authors say. ■

Henoch-Schoenlein purpura: Association with unusual vesicular lesions

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ABSTRACT. *The characteristic dermatologic manifestations of Henoch-Schoenlein purpura (HSP) have been well-described. This report presents a 5-year-old male with HSP who developed atypical vesicular lesions in association with HSP. Vesicular eruptions occasionally can be a part of the polymorphous rash of HSP.*

KEY WORDS: Henoch-Schoenlein purpura, Vesicular lesions, Polymorphous rash

HENOCH-SCHOENLEIN purpura (HSP) is an acquired disorder of unknown etiology that is characterized by variable visceral and joint abnormalities and a typical nonthrombocytopenic purpuric rash having a characteristic appearance and distribution.[1,2,3,4] The rash, which classically presents as crops of pale pink macular or urticarial lesions, is most often located in gravity-dependent areas. Petechiae develop in the distribution of the lesions and may become confluent. As the eruption fades to a brownish hue, new crops of lesions may occur, giving the rash a polymorphous appearance. The rash may persist for weeks or be transient only to recur.[2]

Occasionally patients with HSP present unusual dermatologic findings, posing a diagnostic challenge to the clinician.[5,6] Recently we cared for a 5-year-old patient with HSP who exhibited an atypical vesicular rash. While several texts mention the occurrence of vesicular lesions in patients with HSP, these statements are poorly referenced.[7,8]

CASE REPORT. Two weeks after the onset of upper respiratory symptoms a 5-year-old white male developed swelling of his left ankle, a petechial rash over his lower extremities, and intermittent cramping abdominal pain. The following day, bilateral knee-swelling developed. Radiographs of his knees were normal. An SMA-12 and sedimentation rate were normal. Microscopic hematuria was present. His symptoms improved with several days of bedrest.

Following an increase in ambulation, his rash became vesicular to bullous in character. The vesicles were filled with serous or hemorrhagic fluid and had spread to involve the extensor surfaces of his elbows, thighs, buttocks, and perioral region. Truncal lesions were absent. The patient passed a guaiac-positive stool and again complained of cramping abdominal pain. At this time he was admitted to the hospital. He had no known allergies.

Physical examination revealed an anxious child with normal vital signs. His skin was covered with erythematous lesions located particularly over his ankles, lower legs, buttocks, elbows, arms, and the perioral region. The lesions varied from discrete petechial eruptions to bullae, and ranged in size from 2-3 mm to 2 cm. Serous or hemorrhagic fluid was present in many of the lesions (Fig 1). Diffuse abdominal tenderness was present. His joint examination was significant for a decreased range of motion and fullness in his knees and right ankle.

A complete blood cell count and sedimentation rate were normal. Bacterial and viral cultures of vesicular fluid were negative. A Tzanck preparation of a lesion was not suggestive of a herpes virus infection. Several blood cultures were negative. Group A beta hemolytic *Streptococcus* was isolated from a throat culture, but anti-streptolysin O and anti-hyaluronidase titers were normal. C3, C4, and IgA were all elevated at 180(86-166 mg/dl N1), 37(13-22 mg/dl N1) and 214(22-137 mg/dl N1) respectively. Febrile agglutinins were negative. Convalescent serologies for adenovirus, Influenza A and B, *Mycoplasma pneumoniae, Herpes simplex,* varicella zoster, measles, and Coxsackie virus were all less than 1:8. A urinalysis on admission revealed microscopic hematuria.

The patient's symptoms resolved with bedrest, only to recur, along with new petechial lesions (Fig 2) when he was allowed to ambulate. The lesions became purpuric before they disappeared. His symptoms resolved with further bedrest and

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further exacerbations did not occur.

DISCUSSION. Except for his vesicular rash, our patient presented with clinical findings and a course compatible with Henoch-Schoenlein purpura (HSP).[1,2] Laboratory data including positive guaiac tests, elevated C3, C4, and IgA, and an abnormal urinalysis, were all consistent with HSP.[4,8,9] Furthermore, laboratory data gathered from our patient ruled out other likely causes of vesicular eruptions.

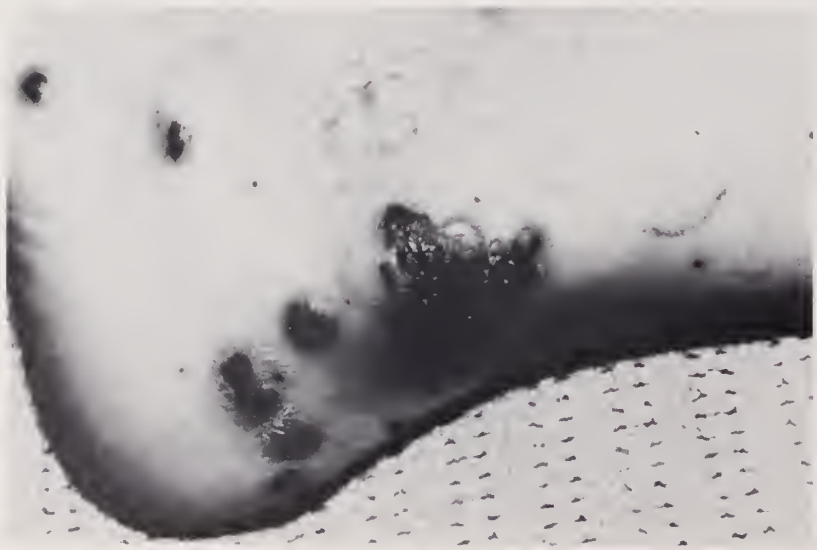
The hemorrhagic, serous bullae, and superficial erosions evidenced in our patient have been uncommon in HSP.[7,8] Atypical dermatological manifestations of HSP have been reported by several authors. Ulcerated lesions, occasionally progressing to gangrene, have been described in HSP.[2,6] None of these reports mention vesicular lesions as a part of the syndrome. Occasionally, lesions may take on the appearance of erythema multiforme with central necrosis and bullae formation.[7,8] Although bullae occurred in our patient, erythema multiforme was absent.

Ruiter and Hadders[10] reported vesicular lesions in a 38-year-old woman as a part of arteriolitis allergica cutis, of which HSP was classified as a subgroup. Pathology of these lesions showed findings compatible with HSP.[11] Visceral and joint involvement were lacking, and it is difficult to determine from this report whether this represents a true case of Henoch-Schoenlein purpura. Winkelmann reviewed 38 cases of small vessel vasculitis or leukocytoclastic angiitis, under which he classifies HSP.[12] He reports either hemorrhagic vesicles or bullae occurring in at least eight cases. However, of these 38 patients, only one was a child and this patient's case report is not discussed.

Our patient's rash did not have the classical appearance of HSP, yet the distribution, course, and appearance of several crops of lesions were typical of this diagnosis. Even though skin manifestations of HSP may be extremely variable,[2,7] the occurrence of clear vesicular eruptions as part of the dermatologic manifestations of HSP has rarely been discussed. This case report is presented to alert clinicians to this atypical presentation of Henoch-Schoenlein purpura.

FIGURE 1—Initial presentation of vesicular eruption. Note the paucity of classical petechial lesions found in HSP patients.

FIGURE 2—Recurrence of rash, showing new and healing vesicular lesions, and petechial eruptions.



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Lithium and Wisconsin—A medicinal trip through history

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ABSTRACT. *Lithium is now well established as the drug of choice for treating manic-depressive disorder. Its history in medicine extends back into the 19th century when it was used for a wide variety of ailments. Over the years Wisconsin has played a prominent role in various aspects of lithium therapy, beginning with the widespread use of mineral spring lithia waters, especially in the Waukesha area in the late 1800s. Lithia beer was brewed in West Bend until the early 1970s and even now a commemorative beer, Lithia Christmas Beer, is made in Eau Claire.*

In 1949 lithium temporarily fell into medical disrepute in this country due to the occurrence of many cases of severe intoxication, one of which was published that year in the Wisconsin Medical Journal *by Dr Henry Peters of the University of Wisconsin Hospital.*

More recently, Wisconsin has become the world's leading source of medically related lithium information following the establishment of the Lithium Information Center in the Department of Psychiatry at the University of Wisconsin Medical Center in Madison. In addition to providing answers to lithium-related questions, the Lithium Information Center is also actively involved in research, the development of educational programs, and publishing in both professional and nonprofessional journals.

KEY WORDS: Lithium; Mineral waters; Salt-substitutes; Lithia water; History; Lithium Information Center

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LITHIUM, the lightest of all solid elements, has a wide and diverse distribution in nature. It can be detected in sparse amounts in plants and animal tissues, in many minerals and mineral springs, and in the sea. Lithium, a constituent of the igneous rock which makes up the Earth's crust, has been present since the dawn of time. It was not until early in the last century, however, that this element was discovered and named.

In 1817, Johan August Arfvedson, a diligent Swedish chemistry student, was busy identifying the components of a newly discovered mineral, petalite. He isolated an alkali-like substance which had some, but not all, the characteristics of sodium and potassium, the other known alkalis of the time. He named this element lithium, after *lithos,* the Greek word for stone.[1]

LITHIUM IN 19TH CENTURY MEDICINE. It was not until 1855 that lithium could be easily separated from its salts, thereby enabling scientists to obtain sufficient quantities of the element to study. Predictably, not long after this, lithium was introduced into medicine. In the mid-1800s, drawing upon the ideas of Lipowitz and Ure, Garrod conducted experiments *in vitro* showing the remarkable dissolution of uric acid deposits on cartilage by lithium carbonate. Garrod erroneously concluded that lithium carbonate could dissolve uric acid concretions *in vivo* as well as *in vitro* and, therefore, would be suitable for the treatment of gout.

Later, Garrod extended his view of uric acid and its role in the causation of disease. According to Garrod, excess uric acid in the blood led not only to anemia and gout but also to other afflictions such as renal calculi, rheumatism, and mood disturbances. Garrod grouped all of these under the descriptive phrase "uric acid diathesis."[2]

Garrod's uric acid diathesis was widely embraced by the medical community in the late 1800s. Accordingly, because lithium urate is the most soluble of all the urates, *in vitro,* lithium administration was thought to be a godsend for the treatment of uric acid disorders.

The heyday of uric acid diathesis came at the turn of the century when a prominent physician, Alexander Haig, published, *Uric Acid as a Factor in the Causation of Disease.* Although Haig differed with Garrod on the mechanism of lithium's action on uric acid in the body, he wholeheartedly supported the uric acid diathesis concept and the use of lithium for its treatment.[3] Uric acid diathesis was so popular in the late 1800s that although there were some who expressed doubts about its validity, all attacks were rebuffed or ignored and uric acid diathesis survived well into the 1900s.

WISCONSIN LITHIA WATERS. The upsurge of the uric acid theory of disease and the consequent use of lithium in its treatment opened the way for medicinal proprietors to flood the market with products containing lithium. Especially popular were the waters of hundreds of mineral spring resorts which dotted the country. Many of them, including some in Wisconsin, extolled their lithium content as a selling point.

The curative value of these mineral waters was conveniently played upon in the suggestive advertising of the resorts and thousands of visitors flocked to the waters in the summer months hoping that the healing water would benefit them. Describing the various summer resorts around the country in 1889, *Harper's Weekly* recommended one in particular. The magazine lauded upon the "sumptuous hotels" and other luxurious accommodations which were available. In addition, its "beauties of nature" and "salubrious climate" were features that made this place attractive to even the most finnicky or sickly of visitors. The fame of its mineral springs and the healing waters which flowed from them were known worldwide. The restorative waters were bottled and shipments made to every part of the United States and to Europe, India, Australia, and China.[4]

> Unbelievably to most people today, the place *Harper's Weekly* was commending was Waukesha, Wisconsin. More recently the renowned mineral springs and the glamour and glitter that they brought to Waukesha has faded. But then, Waukesha was known as the Saratoga of the West (after Saratoga Springs in New York), and the Waukesha newspapers celebrated the town's good fortune. In March 1869, the *Waukesha Freeman* printed,
>
> "There has gurgled forth a fount of God's elixir of life and the afflicted of every country will look here for a revival of lost hopes," the paper said, "What Saratoga is to the East, Waukesha is ultimately destined to be to the rest of the world, a health-restoring resort for suffering humanity".[5]

Before long, accommodations became scarce; and during some busy summer months, visitors had to be turned away. Then, in 1874, the Fountain Spring House was opened. It was the largest and most prestigious hotel in Wisconsin with 800 guest rooms and a lavish formal dining room which seated 500 people. The management of this extravagant hotel realizing that money came from healthy as well as ill guests, offered every kind of amusement that a wealthy 19th century visitor could desire. So Waukesha, in addition to becoming a mecca for the afflicted, became a mecca for society.[6]

One of the largest companies in Waukesha which specifically advertised the lithium content of its water was White Rock Mineral Spring Company. The company was prosperous, and as late as 1920 it was bottling 120,000 bottles of lithia water per day. Although lithia water is no longer among their products, the White Rock Corporation still has nationwide distribution and their trademark, the scantily clad nymph, Psyche, is widely recognized.[7]

Other Waukesha companies which exploited the presumed beneficial lithium content of their waters were the Waukesha Water Company which bottled Boro lithia water, the Waukesha Lithia Spring Company, and the Burr Lithia Springs. In 1892 Waukesha spring water came into national prominence when a pipeline was built to Chicago to supply fresh spring water to the World's Fair. By this time, competition between the various spring companies was so intense that proprietors began to mislead the public, stressing the presumed uniqueness of each spring's curative powers.

In the great spring era, a cure could be found in Waukesha, Wisconsin, for everything from diabetes to "female weakness." In particular, the lithia spring water was said to cure inflammation of the kidneys, urinary infections, dyspepsia, Bright's disease, gout, and rheumatism.[8,9,10]

About the same time that the Waukesha resorts became popular, similar mineral spring resorts and companies appeared throughout the country. Among those promoting lithiated waters were the Buffalo Lithia Springs of Virginia, the Sweetwater Park Hotel of Lithia Springs, Georgia, the Londonderry Lithia Spring Water Company of New Hampshire, and Johannis-Lithia Water of New York.

LITHIA BEER—WEST BEND. Lithia spring water was not the only product made in Wisconsin with marketing based on its lithium content. Just north of Waukesha, in West Bend, Wisconsin, a small brewery was founded in 1849 by a German immigrant, Batthazer Goetter. An artesian well in the basement of the brewery supplied the water for the beer and prior to 1911 the label read "brewed with lithium water." The name of the beer was shortened to Lithia Beer in 1919. This name became widely known. According to Dorothy Williams in the *Spirit of West Bend,*

> "So popular was the name Lithia Beer that many families in the northern part of Washington County use little tea or coffee, for Lithia Beer has taken its place."[11]

Prohibition nearly ruined the small brewery; and during those years, the company bottled a non-alcoholic beverage called "Lithia Be Sure." The brewery reluctantly closed its doors in West Bend in 1972. The Walter Brewing Company located in Eau Claire, Wisconsin, was the last owner. It now bottles the commemorative Lithia Christmas Beer during the holiday season.

THE DECLINE OF LITHIA WATERS. The escalating enthusiasm over the mineral springs and lithia waters was dampened slightly when, before the turn of the century, the US Bureau of Chemistry studied the current lithia waters on the market in the United States. Amazingly, all of the lithia springs, including some of the most popular, were found to contain only spectroscopic amounts of lithium. After writing an opinion on the Buffalo Lithia Springs water case, the Supreme Court of the District of Columbia said,

> "For a person to obtain a therapeutic dose of lithium by drinking Buffalo Lithia Water he would have to drink from 150,000 to 225,000 gallons of water per day." It was further testified, without contradiction, "that Potomac River water contains five times as much lithium per gallon as the water in controversy."[12]

These reports led zealous proprietors to begin marketing lithia tablets and artificial lithia waters. The various tablets were advertised as being "accurate, convenient and permanent," and they were welcomed by the public. By 1907 the *Merck Index* listed 43 different medicinal compounds containing lithium. Unfortunately, as the popularity of lithia tablets and "homemade lithia water" increased, so did the risk of lithium toxicity.[13] Both Kolipinski in 1898, and Cleaveland in 1913, reported cases of lithium toxicity.[14,15] These reports, for the most part, went unheeded and did not significantly lessen the fashionability of lithium preparations.

LITHIUM AS A SALT-SUBSTITUTE—MADISON. The next important chapter in the lithium story lasted only about a year. In the late 1940s low-salt diets were used to treat high blood pressure and heart failure. To make these diets more palatable, lithium chloride was introduced as a salt-substitute, and in 1948 several US companies began marketing the product. The Federal Food, Drug and Cosmetic Act did not require food products to be tested before they went on the market, so in spite of the fact that lithium toxicity had been documented previously, its use as a salt-substitute was unrestrained. It did not take long before cases of salt-substitute linked lithium toxicity were recognized.[16,17]

In 1949, Dr Henry A Peters, now a Professor of Neurology at the University of Wisconsin Hospital and Clinics in Madison, published a paper in the *Wisconsin Medical Journal* entitled "Lithium Intoxication Producing Chorea Athetosis with Recovery." In this article he described a patient with salt-substitute induced lithium toxicity.[18] In an interview with the author (BR), Peters explained that his diagnosis was facilitated by a headline he happened to glance at in the February 19, 1949, *Wisconsin State Journal.* In bold print the headline read "SALT-SUBSTITUTE KILLS."[19] Four deaths linked to several lithium chloride products led the Food and Drug Administration (FDA) to withdraw these salt-substitute preparations from the market in early 1949. Such a fervor was created by the salt-substitute calamity that lithium was not accepted by the US medical community for treatment of any disorder for many years.

LITHIUM IN MODERN PSYCHIATRY. Ironically, in 1949 on the other side of the globe, an Australian psychiatrist, John Cade, reported the successful use of lithium in the treatment of mania.[20] His findings were subsequently confirmed in Europe, and over the years lithium has become one of the most dramatically effective treatments available to psychiatry.*

The United States, however, was not interested in exploring lithium's potential for use in psychiatry in 1949. In fact, it was not until 1970 that the FDA approved the labeling of lithium carbonate

*Lithium was actually used to treat mental illness many years earlier. Haig, in 1900, interlaced manic-depressive disorder with the theory of uric acid diathesis and, consequently, used lithium in its treatment.[21] Furthermore, a Danish physician, Carl Lange, published a paper in 1886 describing what he termed periodic depressions. Lange noticed peculiar urinary sediments excreted by his depressed patients which he incorrectly believed to be deposits of uric acid. Believing this, Lange prescribed lithium prophylaxis for this condition. Lange's work received initial acknowledgment but was quickly forgotten. It was not until 1949 that Cade introduced lithium into psychiatry once again, really beginning the modern era of psychopharmacology.[22]

for the treatment of manic episodes of bipolar (manic-depressive) disorder. Four years later, the FDA approved lithium for maintenance therapy of bipolar disorder. Now, based on information from lithium clinics around the world, it is estimated that 1-2/1000 of people with access to proper medical care are being treated with lithium.[23] Its potential for use in other areas such as depression, alcoholism, premenstrual syndrome, aggression, and schizophrenia are being investigated.

LITHIUM INFORMATION CENTER—MADISON. Because of the growing need for knowledge and easy access to information regarding lithium and its uses in medicine, the Lithium Information Center was established in 1975 at the University of Wisconsin Medical School in Madison. Over the years, the Center has become the world's leading resource for medically-related lithium information, answering well over 1000 requests yearly. Located in the Department of Psychiatry at the University of Wisconsin Center for Health Sciences, the Center is actively involved in acquiring and cataloging all publications dealing with lithium and medicine (well over 12,000 and growing at a rate of over 1000 per year). These articles are accessible through a computerized data base so that requests for information can be handled efficiently, rapidly, and comprehensively. The staff of the Lithium Information Center also is actively involved in research, development of educational programs, and publishing both professional and nonprofessional articles on the subject.[24]

SUMMARY. Over the last 100 years lithium usage has gone through a metamorphosis. A once mysterious, miraculous, and presumed beneficial component of beer and mineral spring waters, lithium is now part of the modern age of psychopharmacology. Wisconsin, once a center for the "medicinal" uses of 19th century lithia preparations, is now internationally recognized as a leader in the modern applications of lithium in medicine.

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AMA Brief Report

Nifedipine offers rapid hypertension treatment

Chewing perforated nifedipine capsules is a safe and effective way to lower blood pressure promptly without parenteral medications, say Jacob I Haft, MD and William E Litterer III, DO in the December 1984 *Archives of Internal Medicine.* Within 13 minutes, blood pressures of 42 emergency-room patients dropped from an average of 205 over 127 to 158 over 88. "There were no side effects and no hypotension even among the 38 patients who had recently received other medications," the cardiologists from St Michael's Medical Center in Newark, New Jersey report. Nifedipine is a calcium blocker. ■

Epidemic typhus acquired in Wisconsin

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ABSTRACT. *A 50-year-old developed a febrile illness in February 1984 characterized by a minimal erythematous rash and prompt response to oral tetracycline. During the month prior to illness, he lived in his cabin in southwestern Wisconsin with multiple flying squirrels. The epidemiologic history and his serological reactions established the diagnosis of "sporadic" epidemic typhus.*

KEY WORDS: Sporadic epidemic typhus, *Rickettsia prowazekii,* Flying squirrels, Cold weather occurrence

FIGURE 1—Flying squirrels (Glaucomys volans) *at feeder in corner of cabin.*

UNTIL recently, epidemic typhus was considered an exclusively human disease caused by *Rickettsia prowazekii* and transmitted by the human body louse. Epidemics usually have occurred in periods of social disruption when malnutrition, crowding, and poor human hygiene abound. Under these conditions, the disease is serious and has a case fatality rate of 10% to 40%.[1]

While the last United States outbreak of typhus occurred in 1922, recent reports have shown that sporadic epidemic typhus is being acquired in the United States.[2] These cases have been seen in persons who live in close proximity to flying squirrels, *Glaucomys volans* in the Eastern woodlands, and *G. sabrinus* in the far West. Most have occurred in the Southeast,[3] but a few cases also have been reported from other states within the range of flying squirrels, and include Arkansas, Illinois, Indiana, Ohio, and California. The following is a case of epidemic typhus acquired from exposure to flying squirrels in southwestern Wisconsin.

CASE REPORT. In January 1984 a 50-year-old university professor developed a dry cough, night sweats, and fever. Over the last eight winters he has had flying squirrels in his log cabin which is located in a wooded area of southwestern Wisconsin. The squirrels have come into the cabin each December and often remained until late April. During the month he became ill, he had regularly fed up to ten flying squirrels from a small feeder located in a corner of the cabin (Fig 1). He recalled no direct squirrel contact, nor was he aware of any recent insect bites prior to his illness.

Examination revealed a temperature of 39 C, blood pressure of 130/80 mm Hg, and a pulse rate of 96. His skin was hot and flushed, and there were numerous, small, punctate lesions on the upper arms and shoulders. Within two days these progressed to less distinct, slightly erythematous, 3-4 mm roundish macules in the same distribution. There were no other remarkable physical findings.

Laboratory testing revealed a white blood cell count of 4800 per cu mm with 46% segmented neutrophils, 24% band neutrophils, 17% lymphocytes, and 9% mononucleocytes. Blood cultures were negative and a urinalysis was normal. The serum aspartate aminotransferase (SGOT) was 85 IU/L, and a lactic dehydrogenase

From the Section of Infectious Disease (WAA) and Section of Allergy and Immunology (VS) of the Gundersen Clinic Ltd, La Crosse, Wisconsin. Reprint requests to: William A Agger, MD, 1836 South Ave, La Crosse, Wis 54601 (phone: 608/782-7300). Copyright 1985 by the State Medical Society of Wisconsin.

(LDH) was 248 IU/L, both slightly elevated. A hepatitis B panel was positive for hepatitis B core antibody, negative for surface antigen, and negative for surface antibody. Other negative tests included a Venereal Disease Research Laboratory slide (VDRL), antinuclear antigen (ANA), and monospot.

A proteus OX-19 titer (Weil-Felix agglutination) obtained on day 10 of illness was positive at a 1:640 dilution, and 21 days later the titer was 1:2560. Serum specimens obtained on days 13, 27, and 76 after illness onset were sent to Todd McPherson, Virus Serology Laboratory, Wisconsin State Laboratory of Hygiene. The complement fixation antibody titers to typhus group antigens were 1:256, 1:64, and 1:16, respectively; the indirect fluorescent antibody (IFA) titers to typhus group antigens were 1:8192, 1:4096, and 1:1024, respectively; and the IFA titers to spotted fever group antigens were 1:128, 1:64, and 1:64, respectively. Aliquots of the three sera were sent to the Centers for Disease Control for specific typhus testing; the antibody absorption technique of the IFA test was used. The IFA titers were as follows: to murine typhus antigen 1:1024, > 1:512, and 1:1024, respectively; to epidemic typhus antigen 1:1024, > 1:512, and 1:512, respectively; and to *R. canada* > 1:512 on the first specimen; the other two were not tested. While a diagnosis of typhus could be made, an antigen specific diagnosis was not made using the antibody absorption technique of the IFA test.

Titers for multiple virus were low and did not change. With the positive OX-19, the patient was started on tetracycline 250 mg four times a day by mouth; and fevers, sweats, cough, and rash rapidly disappeared (Fig 2).

DISCUSSION. To our knowledge, typhus has not been previously reported to have been acquired in Wisconsin; and, therefore, other infections should be considered when attempting to rule out rickettsial illness acquired in our state. First, Brill-Zinsser disease, or recrudescent typhus, is a mild form of this illness, usually not associated with elevations of Weil-Felix titer. In the United States this unusual illness has been seen in Eastern Europeans who have had typhus prior to immigrating to this country. Recrudescence occurs during times of physical stress.[1]

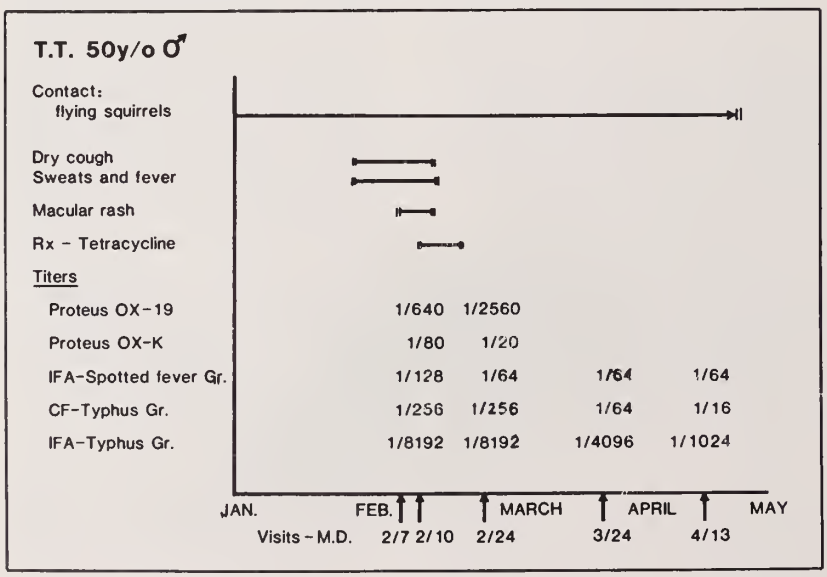
Another possibility is Rocky Mountain spotted fever (RMSF) caused by *Rickettsia rickettsii*. This illness, however, is extremely rare in Wisconsin with only three reported cases in the state in recent years[4] (personal communication Jeffrey P Davis, MD, Wisconsin State Epidemiologist). RMSF follows the bite of an infected tick and thus usually occurs from March to October.[5]

A third consideration, endemic or murine typhus, is caused by *Rickettsia mooseri*. The vector of this illness is the oriental rat flea, *Xenopsylla cheopis*. Endemic in the Southeast and the coastal areas of Texas and Louisiana, in areas of shanty housing with rats,[6] murine typhus is not a disease commonly recognized in Wisconsin.

We believe our patient had epidemic typhus secondary to exposure to infected flying squirrels. Characteristics of this type of "sporadic" epidemic typhus are: (1) occurrence out of the season for Rocky Mountain spotted fever [March-October]; (2) absence of a rash (20%), or presence of a centrifically spreading rash; (3) absence of a tick bite; (4) occurrence in a locale with an extremely low incidence of Rocky Mountain spotted fever; and (5) the presence of an unusual serological reaction favoring the diagnosis of typhus rather than Rocky Mountain spotted fever.[3]

This patient was typical of the other sporadic cases of epidemic typhus including the mild nature of his illness. There have been no fatalities among the more than 30 cases reported since 1976.[7] In addition, rashes have been absent in approximately 20% of cases, and otherwise fairly mild in most others. Recovery has been generally rapid following the use of tetracycline or chloramphenicol, although one patient had a stroke

FIGURE 2—Clinical data and serologic titers of patient.



shortly after recuperation from this illness.[3]

Most cases of sporadic epidemic typhus have been associated with exposure to flying squirrels, usually, *Glaucomys volans.* In the early winter months these squirrels often enter human dwellings, and during the winter they are more likely to be carrying *R. prowazekii.*[8,9] Potential vectors that could transmit Rickettsia from the flying squirrels to the human host include a flea *(Orchopeas howardii),* which when infected carry only small numbers of *R. prowazekii* but will bite humans, and a squirrel louse *(Neohaematopinus sciuropteri),* which can carry this Rickettsia in large numbers, but rarely bite humans.[10]

R. prowazekii strains that have been cultured from blood and urine of flying squirrels in the United States have demonstrated DNA hybridization and restrictive endonuclease studies to be slightly different than the *R. prowazekii* strains from Europe (personal communication JE McDade, Centers for Disease Control). It has not been determined whether *R. prowazekii* infections of the squirrel population in the United States were present before European immigration, or whether the *R. prowazekii* organism was imported to this country with subsequent mutation.

As long as there is no major disruption of society where malnutrition, crowding, and lice become prevalent, this disease will probably remain rare. However, physicians are cautioned to consider *R. prowazekii* infection when evaluating an unexplained febrile illness which follows exposure to flying squirrels. No isolate from a patient has been obtained. Therefore, prior to antibiotic therapy, a clot of blood and 10 ml of urine, both on dry ice, should be referred to a laboratory which can *safely* attempt rickettsial cultures.

A preventive measure would be to exclude flying squirrels from living in human dwellings and sealing the access ports for the squirrels. However, our patient was unwilling to do this; and, therefore, we have recommended that any future "cabin mates" receive a typhus vaccination.[11] In addition, if any visitors become ill, they will be treated with chloramphenicol or tetracycline which, if begun early, is very efficacious. Finally, Wisconsin physicians should be aware that this infection is present in our state, and any suspect cases should be reported to the Acute and Communicable Diseases Section of the Bureau of Community Health and Prevention, Division of Health, Wisconsin Department of Health and Social Services.

ACKNOWLEDGMENT: The authors wish to thank the Gundersen Medical Foundation Ltd for its financial assistance, and Jeffrey P Davis, MD for his helpful discussions.

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Commentary

Epidemic typhus in Wisconsin

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Madison, Wisconsin

IN THIS ISSUE of the *Wisconsin Medical Journal,* Doctors Agger and Songsiridej report the initial observation of transmission of apparent epidemic typhus in Wisconsin.[1] While the diagnosis of illness due to *R. prowazekii,* the etiologic agent of epidemic typhus, is highly likely in this case, an antigen specific diagnosis using the absorption method of the indirect fluorescent antibody (IFA) test could not be made. If the antibody absorption technique is incorporated with the IFA test, epidemic typhus, in most instances, can be differentiated from endemic or murine typhus.[2]

The etiologic agent of endemic typhus is *R. typhi.* A more highly specific toxin-neutralization test can be used to clearly identify the etiology of the infection.[3] Additional antigen specific testing of this patient's sera is warranted since transmission of epidemic typhus has not been previously documented in Wisconsin.

Of 30 previously reported cases of epidemic typhus reported in the United States since 1976, 26 have occurred in the Eastern and Southeastern United States and four have occurred in the Midwest, two cases in Indiana and one case each in Illinois and Ohio.[4]

Epidemiologic evidence in this case strongly supports a diagnosis of epidemic typhus. The transmission of *R. prowazekii* infections from flying squirrels to humans is unproven; however, it is strongly suggested by the high prevalence of *R. prowazekii* and the isolation of the agent from flying squirrels[5,6] and by the observation that nearly 60% of patients have handled flying squirrels or their nests or have reported squirrels in their homes. The occurrence of the current case in January is highly consistent with the 70% occurrence during the colder months when flying squirrels tend to nest in homes.[4]

While a serologic study of other potentially exposed individuals was not conducted in association with this case, a recent report of a small community study has suggested that unrecognized infection in the vicinity of cases of epidemic typhus is uncommon, even among residents of homes in which flying squirrels have been present.[7]

As Doctors Agger and Songsiridej have noted, the Section of Acute and Communicable Disease Epidemiology, Wisconsin Division of Health, is interested in reports of cases of typhus preferably made as soon as the illness is suspected, and will be pleased to assist in the diagnosis, attempted isolation of rickettsiae, and any additionally warranted evaluation.

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AMA News Report

Tissue abnormalities twice as likely for DES-exposed women

Women prenatally exposed to diethylstilbestrol (DES) are twice as likely to develop tissue abnormalities identified as precursors to the most common forms of cervical and vaginal cancer, according to results of a seven-year study appearing in the December 7, 1984 *Journal of the American Medical Association.*

The incidence rate for dysplasia (abnormality of development) was 15.7 cases per 1000 for exposed women compared with 7.9 cases for a control group of women not exposed, reports the study conducted by the National Collaborative Diethylstilbestrol-Adenosis (DESAD) Project. Commissioned by the National Cancer Institute in 1974, the study followed 3980 women exposed in utero to DES, and 1033 women not exposed.

"The evidence regarding dysplasia should not be a cause for alarm among exposed women, but rather a caution that any exposed woman should continue to have yearly examinations as the DESAD investigators have advised all along," said Stanley J Robboy, MD of New Jersey Medical School, the multi-clinic study's principal investigator. He points out that although DES-exposed women develop dysplasia twice as frequently as controls, it is not known how many will subsequently develop squamous cell carcinoma, the cancer associated with dysplasia.

"Our findings won't change the manner in which we follow our DES-exposed patients," Robboy said. "However, it is important that those women be followed over time by a physician who can detect changes in the cervix and vagina. All women should have a yearly pelvic examination and PAP smear and, if it appears necessary, a biopsy. Should any abnormalities surface, these women should promptly go to a physician experienced in the examination of women who have been exposed to DES."

The DESAD study was conducted in clinics at Boston's Massachusetts General Hospital, the Mayo Clinic in Rochester, Minnesota, the Gundersen Clinic in La Crosse, Wisconsin, Baylor College of Medicine in Houston, Texas, and Cedars Sinai Medical Center in Los Angeles, California. ■

Is high too low? A commentary by the Wisconsin State High Blood Pressure Advisory Committee

Frank D Gutmann, MD, Milwaukee, Wisconsin

FIVE YEARS have elapsed since this journal published the article entitled "Wisconsin High Blood Pressure Control Program—involving the physician."[1] In January 1985 the program will make several important changes in light of the publication of "The 1984 Report of the Joint National Committee on the Detection, Evaluation, and Treatment of High Blood Pressure" (hereafter referred to as "The 1984 Report").[2] This communication will attempt to clarify these changes.

The basic aim of the state program is to coordinate existing health resources for high blood pressure control through local geographic networks that incorporate the uniform state guidelines for high blood pressure detection, referral, and patient education. The program has been highly successful, in great part through the understanding and cooperation of physicians statewide. It is essential for the continued success of the program that physicians fully understand what the changes in these guidelines are, as well as the reasons for altering these guidelines which are *intended for use at screening sites.*

After a careful review the State Advisory Committee, a technical advisory group to the program, adopted (with minor modification) the new blood pressure criteria set forth in The 1984 Report, as depicted in Table 1. The Advisory Committee then concentrated its efforts on establishing levels of blood pressure to be used for the purpose of rescreening and/or referring screenees from state-endorsed screening sites to their physicians. The outcome of the Committee's deliberations is summarized in Figure 1.

Some of the items in Figure 1 clearly represent modifications of the recommendations in The 1984 Report as well as changes from the previous state guidelines. These modifications and/or

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Members and staff of the Advisory Committee include:

Constantine Panagis, MD, *Chair*
Health Commissioner, City of Milwaukee-Health Department, Milwaukee

Richard Dart, MD
Specialist in hypertension and nephrology, Marshfield

Theodore Goodfriend, MD
Faculty, University of Wisconsin, Madison; specialist in hypertension, VA Hospital, Madison

George Griese, MD
Pediatric cardiologist, Marshfield

Frank Gutmann, MD
Faculty, University of Wisconsin Medical School, Milwaukee Clinical Campus; Head of Nephrology Section, Mount Sinai Medical Center, Milwaukee

Linda Sunstad, RD, MPH
State Division of Health, Madison

Marie Vick, RN, PHN
Coordinator of the Douglas County High Blood Pressure Control Program, Superior

Mary Manering, RN
Consultant to the Wisconsin High Blood Pressure Control Program, State Division of Health, Madison

Thomas Schuler
Director, Wisconsin High Blood Pressure Control Program, State Division of Health, Madison

TABLE 1—*Blood pressure criteria for adults 18 and older*

	SYSTOLIC		DIASTOLIC		BLOOD PRESSURE
If	Less than 140 mmHg	and	Less than 86 mmHg*	then	Normal
If	Less than 140 mmHg	and	86 mmHg-89 mmHg	then	High normal
If	140 mmHg-159 mmHg	and	Less than 90 mmHg	then	Borderline isolated systolic
If	160 mmHg or higher	and	Less than 90 mmHg	then	Isolated systolic
If	140 mmHg or higher	and/or	90 mmHg or higher	then	Elevated

*These criteria differ from The 1984 Report only in that 86 mmHg replaces 85 mmHg throughout.

changes warrant comment and explanation:

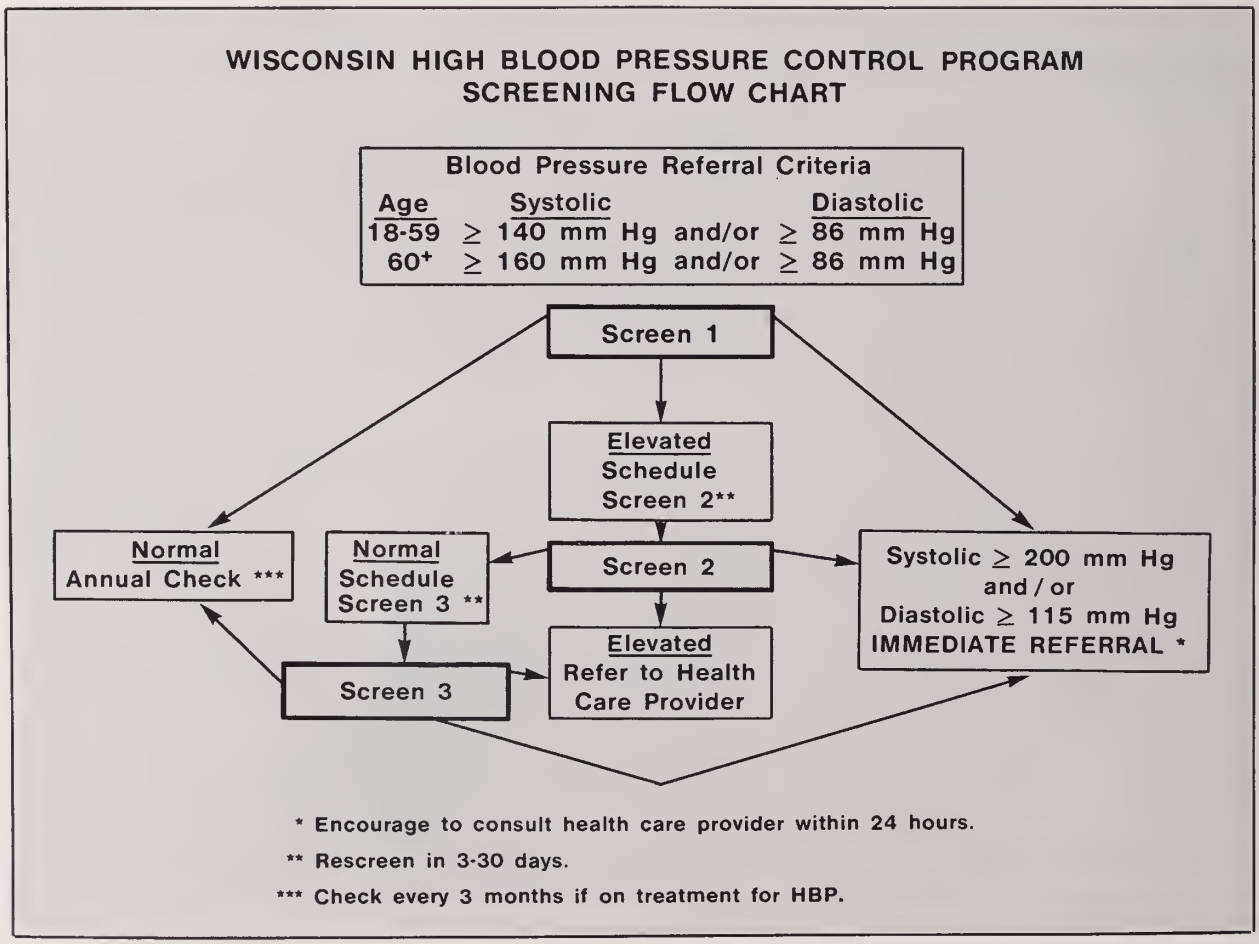
① The Advisory Committee felt that a recommendation to refer persons with borderline isolated systolic blood pressure (Table 1) who were ⩾ *60 years* of age (as recommended by The 1984 Report), might alienate some physicians in the state, particularly in underserved and/or rural areas. Because the number of elderly persons with a blood pressure in this category is large and the benefit of treatment not clearly established, the resultant influx of such referrals might unnecessarily overburden some health-care providers. Therefore, persons ⩾ 60 years of age with borderline isolated systolic blood pressure will not be referred.

② As in the past, a person with a blood pressure that meets the criteria for referral on *two of three screenings* will be referred. Every effort will be made to remind the referring screeners to assiduously *avoid the term* "hypertension," in favor of the term "elevated blood pressure." The Committee felt that nonphysicians should not use a diagnostic label at a screening site.

③ The same referral guidelines are recommended for *persons already on treatment* as for those who are not on treatment. However, persons already on treatment, and whose blood pressure is normal and therefore not recommended for referral, will be asked to have a recheck of their blood pressure every three months (rather than within one or two years) to encourage compliance with treatment.

④ Rescreening for blood pressure readings higher than normal within 3–30 days (rather than within two months) is recommended with the hope that a recommendation for more prompt rechecking will enhance compliance. Furthermore, persons with either a blood pressure of ⩾ 115 mmHg diastolic or ⩾ 200 mmHg systolic will be encour-

FIGURE 1



aged to consult their healthcare provider *immediately* (within 24 hours). This advice is intended to help convey to such persons the urgent need for evaluation.

⑤ All persons should have their blood pressure checked at least annually, regardless of their cardiovascular risk since this risk may not be accurately assessed at a screening site. By contrast the 1984 Report recommends either one *or* two year followup, depending upon this risk.

⑥ The most important, and surely the most controversial change to be made by the program is the referral to a physician of all adults with confirmed diastolic blood pressure of ⩾ 86 mmHg, rather than the previously employed ⩾ 90 mmHg. If the diastolic blood pressure is ⩾ 86 mmHg and < 90 mmHg with systolic blood pressure below referral threshold, the screenees are told that their blood pressure is high normal, and they are tracked in the same way as those with elevated diastolic blood pressure; *ie,* ⩾ 90 mmHg.

There will be a significant increase in the number of persons referred to physicians from screening sites as a consequence of lower referral thresholds. It clearly *is not* the intent of the State Advisory Committee to dictate therapy. It *is* the intent of the Advisory Committee to encourage health promotion and preventive medicine. Most persons in the population will benefit from modifying their cardiovascular risk factors. The Committee felt that persons with high normal blood pressure were especially suitable candidates to be considered for nonpharmacologic attempts at reducing cardiovascular risk. In promoting such interventions to their patients, physicians throughout the state could in turn make a major impact on lowering or preventing a further rise in blood pressure, modifying cardiovascular risk factors, or both.

The Advisory Committee sincerely welcomes comments by state physicians on this issue.

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Editorial Board comment: We are aware that some physicians have little confidence in mass screening of blood pressures. Readings are less accurate in an unfamiliar or crowded surrounding, and physicians are becoming less apt to interpret moderate systolic pressure increase as abnormal. Blood pressures, both systolic and diastolic, may increase with age of the person. We might ask another question: "At some point will there be reasonable 'nonpharmacologic' therapy for elevated blood pressure?" The greatest problem in detection seems to be related to the precise determination of the diastolic reading; *eg,* (1) listening over the artery, (2) distinction of change of sound vs absence of sound, and (3) hearing ability of examiner.

AMA Brief Reports

AMA book wins award

The American Medical Association Guide to WomanCare will receive one of the 1984 American Health Book awards offered by American Health Magazine. Chief editor T George Harris says, "It's not often that an association turns out a focused piece of work like WomanCare. We were very impressed by the book." ■

Linguistics offers study tool for aging

Linguistic analysis of language used by the aged may offer the best answer to whether aging is a natural process, the result of a continuum of minor pathological insults, or a combination of both, says Macdonald Critchley, MD, FRCP, of National Hospital, London, in the November 1984 *Archives of Neurology.* He points out that some writers use more verbs and fewer adjectives as they age, and that the aged often use fewer different types of words within language blocks than do young adults. He believes linguistics can make an important contribution to the understanding of the aging process. ■

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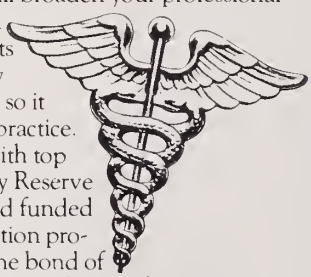

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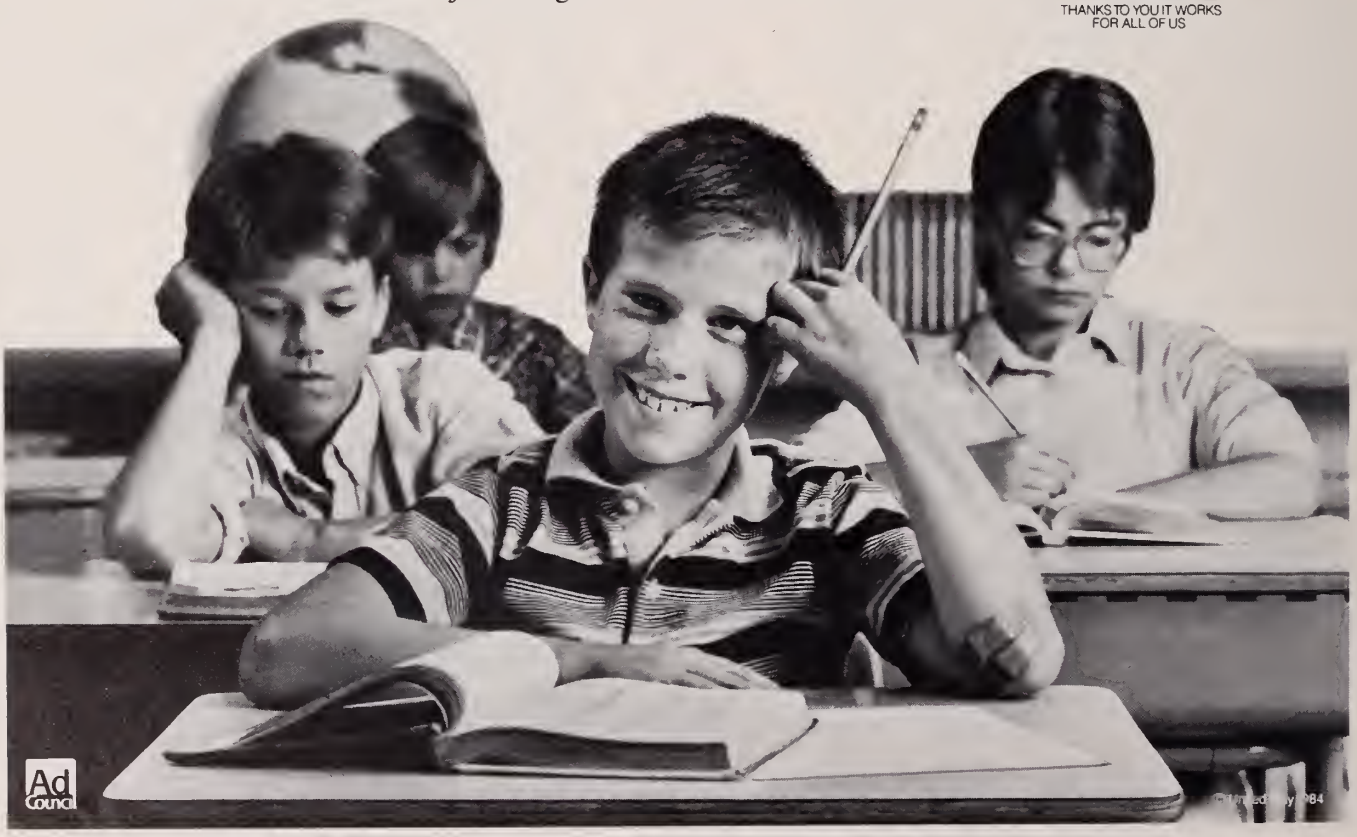

Highlights of AMA House of Delegates Meeting, Dec 2–5

Action on topics ranging from boxing to joint ventures occupied the AMA House of Delegates at its recent Interim Meeting in Honolulu. A summary report of the AMA's actions is offered by the Wisconsin delegation to the AMA —Henry F Twelmeyer, MD, Milwaukee, chairman. Details or further information on any report or activity of that AMA session are available through the delegation by contacting Joan Pyre at the State Medical Society office.

AMA opposes risk-sharing for DRG allowances: The AMA Judicial Council evaluated the ethical implications of risk sharing arrangements whereby the attending physician would participate in the hospital's reimbursement if an individual Medicare patient's costs were kept below the DRG allowance. The physician likewise would share in losses if DRG allowances were exceeded. The AMA House opposes such arrangements.

Physician ownership in commercial ventures: Guidelines were adopted on issues related to potential conflict of interest involved in physician ownership of healthcare facilities, equipment, or pharmaceuticals. The AMA Judicial Council concludes that physician ownership is not in itself unethical but identified five guidelines for addressing potential conflicts.

Surrogate motherhood: The Judicial Council ruled that "surrogate motherhood presents many ethical, legal, psychological, societal, and financial concerns and does not represent a satisfactory reproductive alternative for people who wish to become parents."

Health insurance discrimination against children: The AMA will seek legislation to prevent tax breaks for employers who do not include prevention services and immunization services for children in their health benefit plans. It will also seek state regulation of self-insured health plans with regard to minimum benefits, accessibility of providers, and quality of care. These are now regulated only by a federal law known as ERISA.

Relative value schedules: The AMA Board of Trustees is vigorously exploring with the federal government and other agencies the development of a relative value scale (RVS) to be used to assure appropriate reimbursement under Medicare and other government programs for both cognitive and procedural types of services. Currently, discussions are going on with the Health Care Financing Administration (HCFA) concerning the use of a RVS instead of a DRG system of paying for physicians or an even less desirable alternative of mandatory assignment for Medicare.

Medicare reform: A special report was issued analyzing the problems associated with the fiscal integrity of Medicare and suggesting that a modified Medicare program be adopted with changes in benefits, payment methods, eligibility, financing, integration with private sector approaches and possibly the use of vouchers. This statement will form the basis for AMA policy in dealing with this issue in the coming months before Congress.

Billing for lab procedures: The AMA will undertake an educational program for its members to differentiate between procedural and professional billing—drawing of a specimen versus interpreting laboratory test results. This is increasingly necessary as Medicare and Medicaid reimbursement regulations restrict payments for both of these processes.

Free choice of doctor and benefit: The AMA was directed to seek legislation mandating that employers of 25 or more persons offer various types of health delivery alternatives whenever an HMO alternative is mandated.

Balance billing: The AMA was directed to publish and mail to American Association of Retired Persons' (AARP) members a pamphlet explaining the AMA position on balance billing for Medicare services. At the same time the AMA was to publicize the discriminatory effects of recent laws providing sanctions for doctors who do not contract with the government under Medicare.

Medicare Participating Directory: The AMA asked state medical societies and local physicians to immediately review the forthcoming MEDPARD (Medicare Participating Physician Directory) to identify any errors or misleading statements and to report these to the State Medical Society and to request the US Dept of HHS to issue public corrections.

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Medical liability: The Board of Trustees of AMA issued an excellent update on medical liability problems in the United States and commended Chief Justice Burger for his recommendation that the American Bar Association penalize attorneys who file frivolous allegations of malpractice. The AMA reports recommend concentrating on risk management, tort reform, and the special problems of obstetrics and gynecology in medical liability.

Health and tobacco: The AMA was directed to inform the federal government of the inconsistency of legislating reduction of certain disease entities while reducing the tax on cigarettes and increasing subsidies to the tobacco industry. AMA will seek increases in cigarette taxes as a further means of containing the use of tobacco.

Funding of medical education: The AMA will support the continuation of current methods of funding both the direct and indirect costs of medical education under Medicare at least until better methods can be found to deal with this issue. There is a threat that further budget cutting will remove support for medical education from Medicare reimbursement and thus undercut the overall funding of medical education in the US.

Joint ventures: The AMA issued a major report (Board of Trustees Report EE) dealing with joint ventures and the incorporation of hospital medical staffs. This is a careful review of the legal and ethical implications of such ventures and is "must reading" for medical staffs of hospitals, especially when considering either incorporation of any kind or joint ventures with the hospital.

Maternal and child health: The AMA adopted a series of major recommendations in support of the surgeon general's policies with regard to maternal and infant health and supported increases in funding levels for maternal and child health programs through the block grant mechanism.

Scientific Affairs reports: The AMA House received a series of reports prepared by the Council on Scientific Affairs. These were adopted, filed, or referred as indicated below.

- —Saccharin and Aspartame; referred for reconsideration of portion dealing with saccharin
- —Guidelines for Reporting Estimates of Probability of Paternity; filed
- —Effects of Toxic Chemicals on the Reproductive Cycle; filed
- —Guidelines for Handling Parenteral Antineoplastics; adopted
- —SI Units for Clinical Laboratory Data; adopted
- —Chelation Therapy; report referred and policy statement adopted—see *News You Can Use* section of this issue
- —Polygraphy; adopted
- —Nicotine Chewing Gum for Cessation of Smoking; filed
- —Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect; adopted
- —Current Status of Therapeutic Plasmapheresis and Related Techniques; filed
- —Scientific Status of Refreshing Recollection by the Use of Hypnosis; adopted
- —Update on Health Effects of "Agent Orange" and Polychlorinated Dioxin Contaminants; adopted

The adopted or filed reports are available upon request.

Hair analysis: The AMA opposed the chemical analysis of hair as a determinant of need for medical therapy. This practice is widely used by chiropractors but it is spreading to other practitioners as well.

Physician collective bargaining: A 30-page report was presented to the House of Delegates dealing with the legal and regulatory ramifications of physician collective bargaining activities and other strategies to promote fair representation of MDs. It concludes that "although physicians may be unable to achieve complete negotiating parity by participating in certain PPO and IPA networks, these forms of partial integration facilitate a closer approximation of provider and payor bargaining positions within acceptable limits of antitrust exposure. Moreover, governmental processes may be employed to promote fair representation of physician interests with a minimum of antitrust risk." At the same time, the AMA concluded that unless physicians are truly employed as that term is defined by the National Labor Relations Board (NLRB), there is no greater advantage to a physician group calling itself a "union" than there is to obtaining representation through a medical society. The full report is well worth reading.

Membership incentives: The AMA approved a series of incentives for physicians who participate in unified membership (concurrent membership in county, state and AMA). Members of unified societies will be eligible for a 10% discount on AMA dues.

Public image: The AMA was directed by the House to initiate immediate programs to strengthen the public's awareness of physicians as patient advocates and to focus public attention on key changes in healthcare delivery and their impact on quality and access. At the same time, AMA is to work with reputable public relations firms to develop a long-range public relations program and to provide assistance to state and county medical societies in this regard.

DRG problems: The AMA continues to seek modification of Medicare rules to assure adequate reimbursement for complications and/or comorbidities which may add significantly to a patient's requirement for medical care under the DRG system. At the same

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time, AMA asks all physicians to document identifiable DRG problems which result in harm or disadvantage to the patient.

PRO operation: The Wisconsin Delegation introduced a resolution opposing inappropriate methodologies for establishing PRO programs. AMA supported in principle the Wisconsin resolution and called upon HCFA to re-evaluate arbitrary admission and quality objectives.

Boxing: The House of Delegates proposed the elimination of both amateur and professional boxing. Even before the end of the meeting, this brought down the wrath of sports writers and a variety of sports interests across the country.

Medical news in lay media: *American Medical News* was directed to present a weekly summary of articles in the lay media concerning medical developments especially of a scientific nature, so that physicians can be informed at least as early as the public gets information through this source.

Violence against medical facilities: The AMA took a strong stand in opposition to violence against medical facilities, including abortion clinics.

Beer advertising: A proposal that alcohol warnings be included in television advertising of beer was debated but referred to the Board of Trustees for further study.

Area pathologist runs for AMA trustee: Gerald Schenken, MD, Nebraska, a pathologist and currently chairman of the AMA Council on Legislation, has announced his candidacy for a seat on the AMA Board of Trustees. Doctor Schenken is supported in his bid for office by the Wisconsin Delegation and other members of the North Central Medical Conference of which Wisconsin is a part. Any physician knowing Doctor Schenken is asked to call or write the State Medical Society to offer assistance in his campaign by writing or otherwise contacting members of the AMA House of Delegates. Your support will be appreciated. Contact Joan Pyre, SMS headquarters.

The Wisconsin delegation during the AMA meeting met with representatives of the North Central Medical Conference (Minnesota, North and South Dakota, Iowa, and Nebraska) to jointly undertake manpower studies dealing with the supply and distribution of physicians. It is recognized that Wisconsin's supply of physicians is primarily affected by migration patterns between Wisconsin and Minnesota, Iowa, Illinois, and Michigan. Efforts will be made to analyze these migration trends and to use the information to assist the respective state legislatures and medical societies in decisions that have to do with this issue. The chairman of this Manpower Study Committee is Kermit Newcomer, MD, La Crosse. ■

Milwaukee's Weinshel named 1985 "Physician-Citizen of the Year"

Leo R Weinshel, MD, Milwaukee, was recognized by the State Medical Society of Wisconsin and the Wisconsin Chamber of Commerce Executives Association November 29 in Milwaukee as "1985 Physician-Citizen of the Year." Doctor Weinshel, who received his award at a special meeting of the Medical Society of Milwaukee County, was honored for his outstanding contributions to his community and patients.

Among the criteria used in selecting the award recipient was how he contributed to the betterment of his community and nation; to the public understanding of the role of medicine, and to the better health and improved quality of life for Wisconsin patients.

A general surgeon in Milwaukee for 47 years, Doctor Weinshel has had many outstanding civic and medical accomplishments.

After graduating from Marquette University School of Medicine in 1937, Doctor Weinshel joined the Army Reserve Corps. During World War II he volunteered for duty at the front and spent more than a year as a surgeon working both in evacuation hospitals and in MASH units in Germany and France—sometimes only five miles from battle lines. After the war ended in 1945, Doctor Weinshel continued to serve in the Army Reserve until 1973 when he retired from service with the rank of brigadier general.

Today, Doctor Weinshel maintains a medical practice in Milwaukee where he specializes in preventive medicine and work-related problems. He serves as clinical professor in both surgery and preventive medicine at the Medical College of Wisconsin.

Over the years, Doctor Weinshel has found time to become one of Milwaukee's most outstanding volunteers. He has devoted countless hours to such organizations as the Boy Scouts of America, Greater Milwaukee Chapter of the Red Cross, Marquette University, the American Legion, the Variety Club, and Badger Boy's State.

Doctor Weinshel's leadership in these organizations has not gone unnoticed. He is the recipient of the Silver Beaver Award and the Silver Antelope Award of the Boy Scouts, the Alumni Service Award of Marquette University, the Man of the Year Award from the

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John Mullooly, MD, president of the Medical Society of Milwaukee County; Mrs and Leo Weinshel, MD; and Darold Treffert, MD, SMS Board of Directors' chairman

continued

Variety Club, and the Outstanding Civilian Service Medal from the Army.

He has served on the Board of Directors of the Medical College of Wisconsin; as medical director, treasurer, and board member of Badger Boy's State; on the executive board of the Boy Scouts of America; on the board of directors of the Greater Milwaukee Chapter of the American Red Cross, as medical director of the Wisconsin American Legion, and on the board of directors of the Marquette University Alumni Association.

Doctor Weinshel has been an active participant in his profession serving as senior attending surgeon and chief of staff from 1962-64 at Milwaukee County General Hospital, and on several committees of the State Medical Society of Wisconsin and the Medical Society of Milwaukee County. He is a fellow of both the American College of Chest Physicians and the American College of Surgeons, and is a founding member of the Wisconsin Chapter of the American College of Surgeons.

In 1939, Doctor Weinshel started visiting the Milwaukee County Jail and other county correctional facilities on a part-time basis. At the time, few other doctors would make the visits. He continued until he became the physician for both the jail and county juvenile detention center. He was instrumental in the certification of the Milwaukee County Jail in 1977 from the American Medical Association's Jail Health Care Accreditation Program. The State Medical Society of Wisconsin was one of six original pilot states to conduct this program to improve the level of health and medical care administered in jails.

In presenting the award to Doctor Weinshel, SMS Board of Directors' Chairman Darold A Treffert, MD, said: "Concern about people and helping them has been a way of life to Dr Leo Weinshel. Because of his example, the community cannot help but better understand and appreciate the role of medicine as well as the contributions made by the medical community as a whole." ■

Annual Meeting resolution deadline

The 1985 House of Delegates sessions will be held April 25-26 in La Crosse. All resolutions must be submitted in proper form to the Secretary's office at SMS no later than February 25, 1985 (two months prior to the first session of the House). It is important that county medical societies, specialty sections, and members submit resolutions early to facilitate early distribution of materials and allow all delegates to adequately represent their county medical society or specialty section. If a resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS staff is available to assist in preparation of fiscal notes. The first session of the House will convene on April 25 and the second and third sessions will be on April 26, 1985. ■

Patient handouts available on Medicare assignment

Posters and statement stuffers for both "participating" and "nonparticipating" physicians in the Medicare program are available from the SMS Membership and Communications Division in Madison. In the case of the nonparticipating physician, the materials indicate that the physician is willing to continue to accept Medicare assignment on a case-by-case basis. Both versions of the statement stuffers and posters inform the patient of the physician's willingness to offer reduced fees in cases of financial hardship. Cost of billing enclosures is $1.50 per 100 plus $3.00 postage and handling and 5% state sales tax. To order a supply for your office, call or write the SMS Membership and Communications Division at PO Box 1109, Madison, WI 53701, or 608/257-6781, toll-free 1-800-362-9080. ■

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Doctor Landis nominated for President-elect of SMS

The House of Delegates Nominating Committee at its November meeting selected the following slate of officers for the 1985 elections to be held April 26 during the SMS Annual Meeting in Milwaukee:

- ***Charles W Landis, MD,*** Milwaukee—President-elect for 1985-86
- ***John J Foley, MD,*** Menomonee Falls—Treasurer for 1985-86 to succeed himself
- ***Duane W Taebel, MD,*** La Crosse—Speaker of the House of Delegates, 1985-87 to succeed himself
- ***Henry F Twelmeyer, MD,*** Wauwatosa; ***Richard W Edwards, MD,*** Richland Center; and ***Cornelius A Natoli, MD,*** La Crosse—AMA Delegates for calendar years 1986-87, to succeed themselves
- ***J D Kabler, MD,*** Madison; ***Kenneth M Viste Jr, MD,*** Oshkosh; and ***Richard H Ulmer, MD,*** Marshfield—AMA Alternate Delegates for calendar years 1986-87, to succeed themselves
- ***Timothy T Flaherty, MD,*** Neenah—Additional AMA Delegate for 1985 (In 1984 the AMA House of Delegates amended the Bylaws to provide for an additional delegate for a constituent association when 75% of its members were also AMA members. Whether Wisconsin will be eligible for this additional delegate in 1985 will depend upon the membership count as of December 31, 1984.)

Biographical sketches and pictures of the candidates will appear in the February issue. ■

Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1984 Membership Directory as published in the July 1984 issue of the *Wisconsin Medical Journal.* Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership records. County transfers will be included when processing has been completed by the Membership Department.

New, reelected, or reinstated members
(complete information)

Changes in specialties and/or Board certification(*)
(changes only with member's name)

By county medical society

ASHLAND-BAYFIELD-IRON

Petry, Thomas S
206 6th Ave West
Ashland WI 54806

BROWN

Kiser, John P
2404 Santa Barbara Dr
Green Bay WI 54303

DANE

Cary, Steve
933 W Johnson St
Madison WI 53715

Denny, John
3140 View Rd
Madison WI 53711

Farley, David R
119 E Johnson St, #1
Madison WI 53703

EM*
Pearlman, Melvyn A
202 S Park St
Madison WI 53715

Saluja, Rajit
2302 University Ave, #311
Madison WI 53705

Van De Loo, David A
2207 Woodview Ct, #12
Madison WI 53713

Wilde, James
1327 Bowen Ct
Madison WI 53715

DOOR-KEWAUNEE

Kimmel, Glenn
1304 First St
Kewaunee WI 54216

FOND DU LAC

DR NR R*
Salo, Bruce C
481 E Division St
Fond du Lac WI 54935

GP GS
Smith Jr, Ernest V
481 E Division St
Fond du Lac WI 54935

GREEN

PD*
Bancroft, John D
1515 10th St
Monroe WI 53566

IM*
Brehm, Joyce
2709 6th St
Monroe WI 53566

IM* CD
Mc Cauley Jr, Charles S
1515 10th St
Monroe WI 53566

KENOSHA

Droege, Elizabeth A
3235 South Johnson St
New Berlin WI 53151

P PN*
Freund Jr, Bernard W
2818 14th Ave
Kenosha WI 53140

OBG
Schellpfeffer, Michael A
1400 75th St
Kenosha WI 53140

LA CROSSE

GS*
Cogbill, Thomas H
Rte 1 Forest Ridge
La Crosse WI 54601

AN*
Dhanak, Kalpana B
1218 North Oak Ave
Onalaska WI 54650

P PN*
Goldbloom, T Joshua
1836 South Ave
La Crosse WI 54601

PM R
Griffith, Mark D
700 West Ave South
La Crosse WI 54601

continued

continued
LA CROSSE

CD EM IM*
Johnson, Gordon L
504 South 28th St
La Crosse WI 54601

PS OTO*
Martin, Lynn T
1836 South Ave
La Crosse WI 54601

IM*
Norenberg, David D
1836 South Ave
La Crosse WI 54601

MILWAUKEE
Mc Inerney, Gerald T
2400 South 90th St
West Allis WI 53227

RACINE
ORS
Zeman, David R
837 Main St
Racine WI 53403

ROCK
FP*
Bowers, Ronald K
2020 East Milwaukee
Janesville WI 53545

IM
Fitzgerald, William M
1905 Huebbe Parkway
Beloit WI 53511

OTO
Lee, Peter U
1905 Huebbe Parkway
Beloit WI 53511

RUSK
DR R*
Ellis, David P
1009 Shade Lane
Ladysmith WI 54848

FP
Sheller, Robert D
906 College Ave
Ladysmith WI 54848

FP*
Stienke, Emil B
906 College Ave
Ladysmith WI 54848

WAUKESHA
OTO
Beste, David J
W180 N7950 Town Hall
Menomonee Falls WI 53051

FP
Carlson, Vernette M
2542 N 124th St, #301
Wauwatosa WI 53226

FP
Googe, Sarah L
338 Lemira Ave
Waukesha WI 53186

FP*
Jayne, Dorothy J
225 Eagle Lake Ave
Mukwonago WI 53149

FP*
Jensen, Thomas R
485 Claremont Ct
Waukesha WI 53186

AN
Judge, Daniel G
1245 Indianwood Dr
Brookfield WI 53005

FP*
Kelly, John E
2109 N Peninsula Rd
Oconomowoc WI 53066

FP
Larsen, Julie N
400 Fairview Ave
Waukesha WI 53186

P PN*
Logan, Michael J
3610 Hickory Lane
Oconomowoc WI 53066

D
Schenck, Beth A
5570 W Roosevelt Dr
Milwaukee WI 53216

R ON
Schewe, Kevin L
8701 Watertown Plank Rd
Milwaukee WI 53226

FP
Tanel Gwendolyn
482 Orchard Ave
Waukesha WI 53186

County society transfers

BARRON-WASHBURN-BURNETT
(from Marathon)
Harrison, James F
995 Campus Dr
Wausau WI 54401

DODGE
(from Sauk)
Caceres, Victor W
130 Warren St
Beaver Dam WI 53916

(from Kenosha)
Steele, James O
Rte 1
Horicon WI 53032

MANITOWOC
(from Racine)
Gommermann, John A
919 Lawton Terr
Manitowoc WI 54220

ROCK
(from Manitowoc)
Horswill, Robert N
2020 E Milwaukee St
Janesville WI 53545

WAUKESHA
(from Dane)
Maday, Gary J
1105 Terrace Dr
Elm Grove WI 53122■

To: *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701

Please correct my listing in the 1984 Membership Directory as follows:

COUNTY MEDICAL SOCIETY _____

SPECIALTY CODE _____ / _____ / _____
(PRIMARY) (SECONDARY) (SECONDARY)

BOARD CERTIFIED IN _____ / _____ / _____
(PRIMARY) (SECONDARY) (SECONDARY)

NAME _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

ADDRESS (FOR DIRECTORY) _____

CITY _____ STATE _____ ZIP _____

PHONE (FOR DIRECTORY) (____) _____

SIGNED _____ DATE _____

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Hospital preparedness in treating radiation accident victims concerns SMS EOH Committee

The SMS Environmental and Occupational Health Committee (EOHC) is continuing to express concern over the lack of preparedness of hospitals in the state to safely treat patients who may become contaminated by radioactive fuel due to a shipment accident. Currently the Northern States Power Company is shipping spent nuclear fuel by rail from Monticello, Minnesota to a nuclear storage site in Morris, Illinois.

Mr Dave Speerschneider of the Division of Emergency Government and Larry McDonnell of the Dept of Health and Social Services-Section on Radiation Protection met with the Committee November 28 to discuss what measures have been taken to assure that area hospitals along the route are prepared to deal with emergency decontamination in the event of a nuclear waste accident.

Mr McDonnell pointed out that the state has no specific charge to assure that hospitals are indeed equipped and prepared to deal with nuclear contamination accidents. All activities to prepare hospitals thus far have been voluntary efforts between the State Division of Emergency Government, the DHSS Section on Radiation Protection, and the Northern States Power Company.

He pointed out that the "Hospital Emergency Department Radiation Accident Protocol," which was prepared by the State Medical Society's EOHC Committee, DHSS, and the Radiation Protection Council, has been distributed to hospitals along the nuclear waste transportation route. JCAH Accreditation Standards require a protocol for radiation accident procedures. State hospitals, as well as hospitals elsewhere in the nation, have been interested in the document.

Furthermore, the Northern States Power Company and state government have jointly sponsored several training sessions where more than 600 hospital personnel and emergency medical technologists have been educated on how to treat radiation accident victims.

Several committee members said they were concerned that there appeared to be no way to insure that hospitals were indeed prepared to deal with an accident if one should occur. Committee Chairman Vernon N Dodson, MD, Madison, said he feared that small hospitals would not have the funding to purchase the equipment necessary to implement a preparedness program. Mr McDonnell concurred and said no specific state monies have been appropriated to address this issue, although Governor Earl has asked the Division of Emergency Government to review the preparedness of local people to respond to nuclear waste contamination accidents. Governor Earl also has asked the Nuclear Regulatory Commission to certify that the trips are necessary. ■

Committee seeks ways to improve organ procurement system

An Advisory Committee on Organ Procurement met at SMS offices November 27 to review the issues surrounding organ donation and referral in the state. The advisory committee, which consists of physicians, nurses, and hospital representatives involved in organ donation, has been asked to respond to a Legislative Council Special Committee on Bioethics regarding methods to increase and coordinate organ donations in the state.

According to national data, Wisconsin has an excellent record when it comes to organ transplantation and procurement. Wisconsin has the highest procurement record in the country as well as a very high transplant-to-population ratio. Moreover, good rapport and cooperation exists between the healthcare professionals involved. The aim of the committee is to increase the effectiveness of an already successful system.

The committee discussed several mechanisms for improving the organ donation and referral process in Wisconsin. Suggestions included:

- Establish a statewide computerized listing of all persons who have signed their driver's license organ donor card. A statewide telephone number for this listing could be used by healthcare professionals to verify the driver's license donation signature.
- Develop a public awareness campaign to promote organ donation via driver's license donor card.
- Prepare a position paper on the entire issue of organ donations

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and transplantation for presentation to Legislative Committee on Bioethics. The paper would promote the ideas mentioned previously as well as include consideration of how to cope legally with coroners' cases, potential ways to eulogize the donor (for the family's sake), and the role of the hospital chaplain in this process.

• Sponsor a state-of-the-art organ transplant conference aimed at educating designated hospital coordinators on the latest issues surrounding organ transplantation, procurement, and donations. ■

Report on school health problems available

The Wisconsin Coalition for School Health Education (WCSHE), of which SMS is a member, has recently completed a report on "Critical Health Problems of Wisconsin's School-Aged Youth." The first part of the document presents the major health problems in Wisconsin's school children and adolescents as identified by the Coalition. The second section focuses on the Coalition's recommendations for reducing the critical health problems of Wisconsin's school-aged youth and improving Wisconsin's school health education delivery and support recommendations.

The WCSHE is composed of 32 professional and voluntary organizations which support the establishment of comprehensive health instruction programs K-12 in all Wisconsin schools. Conrad Andringa, MD, Madison, and Diane Upton of the SMS staff represent the State Medical Society on the Coalition. Copies of the Coalition document are available by contacting the SMS Membership and Communications Division in Madison. ■

SMS leaders discuss health issues of the elderly with Coalition of Aging

SMS President Flaherty and Secretary Thayer met for several hours Thursday, December 13, with the Board of Directors of the Wisconsin Coalition of Aging Groups. Nearly 50 over-65 leaders of volunteer local aging groups were represented.

Doctor Flaherty outlined the Society's policy regarding Medicare assignment and its consideration for all Wisconsin's low-income citizens. He explained physicians' worries that federal-state regulations may compromise the ability to provide adequate and compassionate care for the elderly, the hazards of the "new rationing" plans such as DRGs and HMO/PPOs, and the need to look for changes in the Medicare system. He also spoke of the malpractice problem and how this contributes to increased costs.

The SMS officials offered to assist local aging groups in dealing with access, cost, and quality problems and encouraged them to work closely with local physicians and medical societies.

The coalition adopted a resolution of appreciation for Doctor Flaherty's visit and directed that continuing dialogue take place between the Coalition and the State Medical Society. ■

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

How they handle drunk drivers in other countries

Australia . . . The names of the drivers are sent to the local newspapers and are printed under the heading "He's drunk and in jail."

Malaya . . . The driver is jailed, and if he's married, his wife is jailed too.

South Africa . . . A 10-year prison sentence and the equivalent of a $10,000 fine or both.

Turkey . . . Drunk drivers are taken 20 miles from town by the police and forced to walk back, under escort.

Norway . . . Three weeks in jail at hard labor, one year loss of license. Second offense within 5 years—license revoked for life.

Finland and Switzerland . . . Automatic jail for one year at hard labor.

Costa Rica . . . Police remove plates from car.

Russia . . . License revoked for life.

England . . . One year license suspension and $250 fine and jail for one year.

France . . . Three year loss of license, one year in jail and $1,000 fine.

Poland . . . Jail and fine and forced to attend political lectures.

Bulgaria . . . A second conviction results in execution.

El Salvador . . . Your first offense is your last. Execution by firing squad.

***

Taken from: "The Impaired Physician Program Newsletter" of the Medical Society of New Jersey, November 1984. ■

Legislative committee backs cap on attorney fees

The Legislative Council Special Committee on Medical Malpractice added to its list of proposed changes in Wisconsin's medical liability laws in December by approving a recommendation to adopt a sliding scale for attorney contingency fees. Under this plan, the percentage an attorney could charge as a contingency fee would decrease as the amount of the award increased. SMS supports this concept as it preserves a greater portion of the award for the claimant.

The Committee has not yet determined the actual percentage limits but an example of the sliding fee system would be to allow fees up to: 33% of awards less than $100,000; 25% of awards between $100,000 and $300,000; 20% of awards between $300,000 and $500,000, or 15% of awards in excess of $500,000.

The Committee also approved recommendations to:

- Implement a surcharge program within the Patients Compensation Fund whereby physicians with poor claims experience would be charged a higher fee than others in the same specialty.

- Require all primary insurers and the Fund to report all paid claims to the State Medical Examining Board.

- Modify the accounting and reserving system of the Fund to limit reserving for anticipated future claims. This recommendation of SMS is directed at lessening the impact of actuarial projections of future claims on current fee assessment.

- Allow periodic (quarterly) payment of Fund fee assessments.

- Reduce the general statute of limitations from 3 to 2 years.

- Provide WHCLIP and Fund coverage for HMOs, PPOs, etc.

At a previous meeting the Committee approved a $1 million cap on malpractice awards.

At a subsequent meeting on December 19, the Committee took the following actions:

- On the recommendation of the Wisconsin Academy of Trial Lawyers, voted to direct the Patients Compensation Panels to not require expert medical testimony. Expert testimony could be voluntarily presented by the plaintiff or defendant. It was indicated that, in the absence of expert testimony, the physician members of the panel would act as the experts themselves. The Committee also discussed, but delayed action on, the State Bar's recommendation to change the composition of formal panels by eliminating one physician member and adding an additional public member. In conjunction with the preceding recommendation, this would yield a panel of one physician, one attorney chairperson, and three public members, and no requirement for expert testimony.

- Supported in concept the creation of physician peer review committees to work with WHCLIP and all other primary carriers, the Patients Compensation Fund, and the State Medical Examining Board. Such committees would review paid claims in conjunction with a surcharge system and would prioritize cases for review by the MEB and make recommendations for disciplinary actions. A specific proposal covering statutory authority, composition, and immunity from liability will be presented to the Committee for final review.

- Voted to increase protections from lawsuits for peer review committees and their individual members, by extending Patients Compensation Fund coverage to these committees, with coverage to apply in all cases except when the Committee is found by a court to be acting in bad faith and willful and malicious intent to discriminate. The Committee also voted to increase the current immunity protection by creating a legal presumption that peer review committees are acting in good faith and requiring a "clear and convincing" standard of evidence to rebut this presumption.

- Voted to recommend that Patients Compensation Panels proceedings be bifurcated with the panel first considering only the question of liability. If liability is found, then the same panel would proceed to consideration of damages.

- Tabled a recommendation that attorneys be required to file a certificate of merit stating that a malpractice claim has been reviewed by a qualified expert and found to be meritorious.

The Committee will next meet January 28. The agenda for the Committee will be to discuss statutory language written by the staff for the Committee and to complete discussion of remaining recommendations. ■

DHSS proposes 3.5% increase in physician reimbursement

The State Department of Health and Social Services has given the Governor a tentative budget for the Medicaid program which includes a 3.5% increase in physician reimbursement. In 1983 SMS was successful in lobbying for a 3% increase in physician reimbursement. This occurred in a 0% increase budget year because SMS was able to effectively illustrate the need for Medicaid to provide an increase based upon escalating practice costs by physicians.

The proposed Medicaid budget also provides coverage for drugs for the "medically needy." This provision will cost $1.4 million in fiscal year 1986 and $1.46 million in fiscal year 1987. The Community Options Program may be expanded to all Wisconsin counties in 1986. This would result in spending $21 million in 1983–85 and $53 million in 1985–87.

The Governor and the Department of Administration now are examining the Medicaid budget proposal and possibly will make modifications to it before presenting it as part of the 1985–87 Biennial Budget proposal to the Legislature in early 1985. The SMS Physicians Alliance Commission also is reviewing the proposal. ■

Medicare assignment sign-up reaches 36% of MDs and DOs

WPS-Medicare reports that 3017 physicians, or 36%, of approximately 8400 Wisconsin licensed physicians (MDs and DOs) have signed Medicare agreements. In regard to other provider groups, WPS-Medicare says that 41% of podiatrists, 21% of chiropractors, 6% of dentists, and 20% of optometrists in the state have signed Medicare participating agreements.

Two directories for the Medicare program have been published. One directory lists only "participating" physicians; *ie,* those physicians who accept Medicare assignment 100% of the time. The other directory lists all Medicare providers along with the percentage of time they accept assignment. ■

WISPAC membership shows 50% increase

Thanks to the support of physicians and their spouses throughout the state the Wisconsin Physicians Political Action Committee (WISPAC) was able to increase its membership by more than 50% in 1984. That represents approximately 30% of the State Medical Society's membership. WISPAC expects an even greater increase in 1985.

Those counties that rate special recognition for reaching their WISPAC membership goals in 1984 are: Calumet, Fond du Lac, Grant, Green Lake-Waushara, Lincoln, Manitowoc, Oconto, Oneida-Vilas, Pierce-St Croix, Price-Taylor, Racine, Rusk, Sauk, Shawano, Trempealeau-Jackson-Buffalo, and Washington. ■

WHCLIP rate may increase 75%

Preliminary indications show that a 75% increase in rates for the Wisconsin Health Care Liability Insurance Plan (WHCLIP) may be necessary to fund next year's claims, actuaries for the Plan told the WHCLIP Actuarial Committee November 28. Although this is only a preliminary report, the actuaries stated they expect little to change between now and when the final recommendations are made in January.

In addition, the actuaries projected that as of December 31, 1984 WHCLIP will show a deficit of $18 million. By comparison, last year's premium income was $10.7 million. The WHCLIP Board of Directors will now have to determine how much, if any, of this deficit will be recouped through next year's rates. Recoupment of any or all of this deficit could raise next year's total premium well beyond the 75% figure. ■

Health Policy Council to look at CON regs

The Health Policy Council (HPC) is in the process of reviewing a proposed change in the certificate-of-need (CON) program to include free-standing birthing centers under the review process. Currently the certificate-of-need review process only applies to hospitals and ambulatory surgical centers. The HPC's Acute Care Committee, which is making the recommendation, is arguing that since free-standing birthing centers are in direct competition with hospitals, they should be subject to the same regulations as a hospital. ■

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. Dues for regular membership in 1985 are $455 for SMS, $330 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin
DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Your membership in organized medicine will help insure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Dues statements for 1985 membership in the State Medical Society of Wisconsin (county medical society membership also required; AMA membership optional but encouraged) are being mailed in November with subsequent reminder notices. For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1985 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1985 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455	$330	Normal County Dues
Resident	45.50	45	Varies
Military Service	-0-	220 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	227.50	330*	Normal County Dues
Over Age 70	227.50	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	20	Varies
Sophomore and Succeeding Medical Student Years	10	20	Varies
Postgraduate—One	10	45	Varies

*Physicians in the following categories may be eligible for exemption from paying AMA dues: (1) Financial hardship and/or disability, (2) Age 65-69 and retired from the practice of medicine, (3) Over age 70 *regardless* of retirement status.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

Malpractice focus of Milwaukee county society meeting

MILWAUKEE: The chances of any one of you getting sued is between one in 10 and one in 15, William Listwan, MD, West Bend, told a group of physicians at a meeting of the Medical Society of Milwaukee County November 29.

Doctor Listwan, who is a member of the SMS Committee on Medical Liability, was part of a four-member panel presentation on the medical liability situation in Wisconsin.

In an overview he gave of the malpractice scene in the state, Doctor Listwan said that deterrence of medical negligence is getting confused with adequate compensation of the patient and this is causing a snowballing effect of awards.

"Business and industry may be one of our biggest allies in trying to reform the system," he said, "as they begin to realize what effect the cost of malpractice is having on their costs."

William Treacy, MD, who is also a member of the Medical Liability Committee, outlined the Medical Society's 19-point plan for reform of the system in Wisconsin. The "heart" of the SMS plan is to establish a sanction system for "repeat offenders."

"If peer review indicates multiple cases of negligence by a particular physician, sanctions, such as surcharges, restricted coverage or referral to the Medical Examining Board should be imposed," he said.

SMS Board member Jerome Fons, MD, Milwaukee, explained the new SMS-endorsed medical liability insurance plan—PICO—to physicians. Doctor Fons said that the Society is represented on claims, underwriting, and advisory committees for the insurance plan.

He pointed out that PICO has agreed not to settle any claims without physician consent. "No other insurance company has this as its policy," he said.

Thus far, the Milwaukee Medical Society is pleased with the plan, and to date 700 physicians have purchased the coverage. The coverage is tied to membership in the State Medical Society, Doctor Fons said, and SMS has been criticized to some degree for this. He defended the policy by saying, "the leadership of the State Medical Society has a responsibility to keep our organization fiscally strong and this plan is an attractive benefit we can offer our members."

Brian Jensen, director of the SMS Physicians Alliance Division began his presentation with the announcement that the Actuarial Committee of the Wisconsin Health Care Liability Insurance

continued

William Listwan, MD

Darold Treffert, MD

William Treacy, MD and Jerome Fons, MD

John Mullooly, MD

Brian Jensen

Staff photos by Diane Upton

continued

Plan (WHCLIP) have recommended a 75% increase in rates for 1985, and that yet to come are increases in the assessments for the Patients Compensation Fund.

"It is figures like these that underscore the necessity for some reform of the system," he said. "Achieving reforms will not be easy for several reasons," Jensen explained. "The majority of the legislators don't even realize there is a malpractice crisis."

He urged physicians to begin contacting their legislators on malpractice issues, get them familiar with the problems. Secondly, doctors should discuss the issue with leaders in business and industry "who have realized that professional liability is just one step away from product liability, and they're concerned about it," Jensen said. Finally, he advised physicians to talk to their patients about malpractice.

Perhaps the biggest thing the medical profession can do to solve the malpractice problem is to do something in "real live peer review," Jensen said.

"One percent of the physicians are causing 20% of the claims. For us to believe that it is only the lawyers that are causing the problem is not fair," he said.

John Mullooly, MD, president of the MSMC, was moderator of the panel.

CES Foundation

CONTRIBUTIONS November 1984

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1984.

Nonrestricted

Chesley P Erwin, MD; Marathon County Medical Society Auxiliary; Winnebago County Medical Society Auxiliary; Dr-Mrs Guy Giffen; Samuel B Harper, MD; Frances Cline, MD; AA Holbrook, MD; Richard H Ulmer, MD; John H Hirschboeck, MD—*Voluntary Contributions*

Restricted

Albert L Fisher, MD; RL Waffle, MD; HJ Hansen, MD—*Black Out Drapes for SMS Board Room*

Lillian E Olson; Laurene De Witt Davidson; Ronald L Lewis; Jacqueline P Dungar; Joseph J Muller, MD; Thomas W Tormey Jr, MD; Sanford R Mallin, MD—*Aesculapian Society Dues*

John T McEnery, MD; Kenneth L Day, MD; Ramona E James; SW Hollenbeck, MD; Mrs. William G Weber; Elsie Egan; George Kress—*Aesculapian Society Dues (Museum of Medical Progress)*

William G Wendle—*Museum of Medical Progress Endowment Fund*

Mrs William D Hoard, Jr—*Museum of Medical Progress ("Beaumont 500")*

Roy Selby, MD—*Museum of Medical Progress ("Beaumont 500")*

Clara Joss Trust Fund—*Medical Research*

State Medical Society of Wisconsin Auxiliary; Winnebago County Medical Society Auxiliary; Dodge County Medical Society Auxiliary—*Harrington-Wright Scholarship Fund*

State Medical Society of Wisconsin Auxiliary—*Workshop on Health*

Memorials

Farrell F Golden, MD—*Robert B Andrew, MD*

Dr-Mrs Farrell F Golden—*Donald Ripple*

Kristin Bjurstrom—*C Appell*

Dr-Mrs William Janssen—*Arthur Erwin; Alex Locke, MD*

John E Dettmann, MD—*Thelma Ford*

State Medical Society—*AH Hermann, MD; Carol D Lorton, MD; Alphonsus M Rauch, MD; Albert M Cohen, MD; Richard D Kennedy, MD; Robert A Andrew, MD; Christian F Midelfort, MD* ■

LINCOLN: Muhammad Yusof Ahmad, MD,* Merrill, has been reelected president of the Lincoln County Medical Society for 1985. Also elected are Charles E Goodell, MD,* Tomahawk, vice-president, and Gail M Amundson, MD,* Tomahawk, secretary.

JEFFERSON: Fifteen members and eight guests were present at the November meeting of the Jefferson County Medical Society. Timothy T Flaherty, MD,* Neenah, president of the State Medical Society, was the guest speaker. Doctor Flaherty spoke on the "Issues of Medicine." At the business session of the meeting, Edward J Hoy, MD,* was elected as secretary-treasurer, and Brigido C Calado, MD,* was nominated for vice-president.

KENOSHA: At its October meeting the Kenosha County Medical Society amended Article III—Eligibility of its Constitution to read: "Every physician practicing medicine in Kenosha County, who is of good moral and professional standing and who does not support or practice, or claim to practice, any exclusive system of medicine, shall be eligible to apply for election to membership, subject to such conditions as may be prescribed by Bylaw, and not inconsistent with the Constitution, Bylaws, and regulation of the State Medical Society. The applicant must demonstrate evidence of their desire to be an integral member of the local practicing medical community. A physician retired from the practice of medicine in Kenosha may continue as an honorary member." ■

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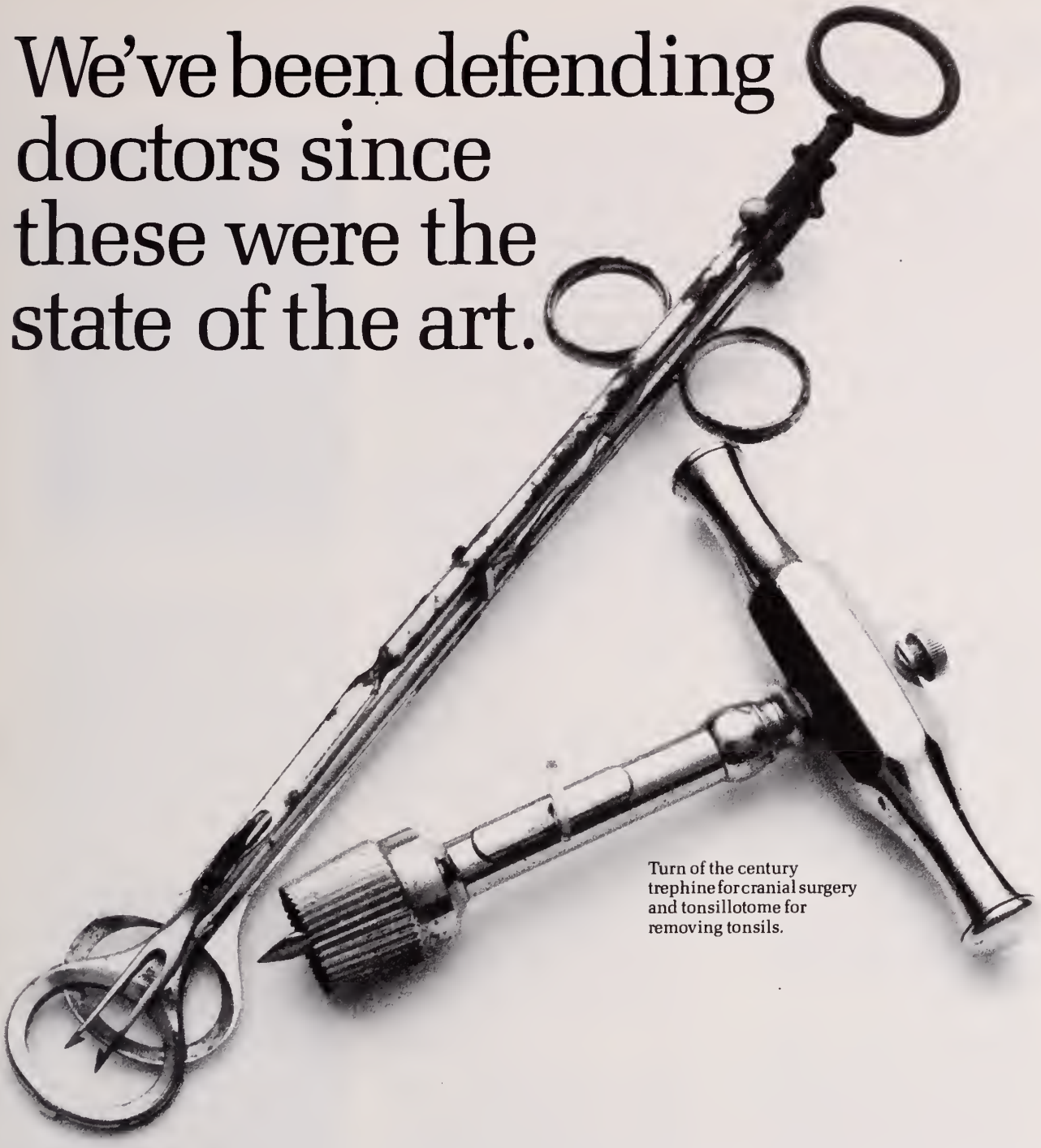

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Robert W Boyle, MD,* Wauwatosa, professor emeritus of physical medicine and rehabilitation at the Medical College of Wisconsin, Milwaukee, won the American Academy of Physical Medicine and Rehabilitation's 1984 Distinguished Clinician Award. Doctor Boyle was director of the physical medicine and rehabilitation department at the Milwaukee County Medical Complex from 1954 to 1978, and is now a consultant at the Veterans Administration Medical Center, Wood. Doctor Boyle was president of the Academy from 1961 to 1962 and also has been its secretary.

William Sybesma, MD,* Fond du Lac, has become associated with the medical staff at Valley View Medical Center, Plymouth. Doctor Sybesma graduated from the University of Iowa Medical School and served his internship at the University of Southern California Medical Center, Los Angeles. His residency was completed at Huntington Memorial Hospital, Pasadena, Calif, and Wadsworth Veterans Administration, UCLA Medical Center. He is on the medical staff of St Agnes Hospital in Fond du Lac.

Jules H Blank, MD, Green Bay, has joined the medical staff of the West Side Clinic. A graduate from Loyola University Stritch School of Medicine, Maywood, Ill, Doctor Blank completed his residency at Southern Illinois University Affiliated Hospitals in Springfield, and a fellowship in hematology and oncology at the University of Connecticut Health Center in Farmington.

John P Kirchner, MD,* Marshfield, recently received the Distinguished Physician Award. The award was presented during the state convention of the American Ex-Prisoners of War in Madison. This was the fifth time the award was presented since it was established in 1968. Mr Stanley Sommers, Marshfield, the organization's national medical research chairman, said Doctor Kirchner wrote a brief dealing with the post-traumatic stress disorder. The disorder is a chronic form of anxiety affecting POWs in the years after incarceration.

Romeo C Soriano, MD, Lancaster, has joined the medical staff of Memorial Hospital of Lafayette County. Doctor Soriano graduated from Far Eastern University in Manila, The Philippines, and served his residency at Hines Veterans Administration Hospital in Illinois.

Beth A Schenck, MD,* Milwaukee, recently joined the Falls Medical Group in the Department of Dermatology. Doctor Schenck graduated from the Indiana University School of Medicine and completed her residency at the Medical College of Wisconsin Affiliated Hospitals. Doctor Schenck also has been appointed to the clinical faculty of the Medical College of Wisconsin, Milwaukee.

Michael F Finkel, MD,* Eau Claire, has been elected vice-president of the Wisconsin Neurological Society for a one-year term. Doctor Finkel is a member of the medical staff of the Midelfort Clinic and is a member of the medical staff at Sacred Heart and Luther hospitals in Eau Claire.

Curtis Radford, MD, Oshkosh, has joined the medical staff of the McDonald Clinic in Winneconne. Doctor Radford graduated from the University of Wisconsin Medical School, Madison, and completed his residency at the Mayo Clinic in Rochester, Minn.

Doctors Gillett and Kreul

George N Gillett, MD,* Racine (left above), and **Randolph W Kreul, MD,*** Racine (right above), examine hand-forged iron forceps used by 19th century doctors to help deliver babies. Doctors Gillett and Kreul both practiced medicine in Racine more than 50 years. They were among members of the Racine County Medical Society who were helping identify old medical instruments stored at the Racine County Historical Museum. Helping catalog the items were members of the Racine County Medical Society Auxiliary. The Auxiliary also plans to do research on 19th century medical practices in Racine County and help the museum upgrade its turn-of-the-century doctor's office exhibit. (Photo by *Racine Shoreline Leader*)

Mark Dickmeyer, MD, Whitewater, has joined the medical staff of the Whitewater Family Practice Clinic. Doctor Dickmeyer graduated from the Indiana University School of Medicine and completed his family practice residency at St Michael's Hospital in Milwaukee.

Henry C Pitot, MD, PhD, Madison, was elected a director-at-large of the American Cancer

Society. Doctor Pitot is director of the McArdle Laboratory for Cancer Research at the University of Wisconsin Medical School, Madison, and also is a professor of oncology and pathology at the University.

Stanley B Marshall, MD,* Hollandale (below), received more than 250 guests at a final farewell party for him. The party was given by members of the combined parishes of St Patrick's Catholic Church and the Hollandale Lutheran Church. Guests came from all over Iowa County, Monroe, Juda, Belleville, Green Bay, Mt Horeb, Monticello, Madison, Janesville, Beaver Dam, and Shullsburg. He also had visitors from Des Plaines, Ill, and Dubuque, Ia. Doctor Marshall retired in 1978 but was "always there for someone to confide in when problems or sorrows were overpowering." (Photo by Jean Lewis, *Dodgeville Chronicle*)

Doctor Marshall

Paul Norton, MD, has begun his medical practice in pediatrics in the Milwaukee suburb of Shorewood. Doctor Norton is a graduate of the Medical College of Wisconsin, Milwaukee. He completed his residency at Milwaukee Children's Hospital where he also served as an assistant professor.

William M Fitzgerald, MD,* retired member and founder of the Beloit Clinic, has presented his doll collection to the Beloit Clinic. In 1947 when Doctor Fitzgerald and two friends started the Beloit Clinic, a patient brought in a doll and gave it to him. Pretty soon another patient brought in another doll from another part of the world. Over the years the collection has grown to 110 dolls and Doctor Fitzgerald deemed it appropriate that the Clinic should have the dolls displayed in a lobby showcase. Doctor Fitzgerald practiced in Beloit from 1947 until his retirement last June.

George M Kroncke, MD,* Madison, University of Wisconsin Medical School associate professor of surgery, recently was elected to membership in the American Association for Thoracic Surgery.

"WATS" LINE FOR MEMBERS

The in-WATS (toll-free) line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

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Internists to sponsor legislative seminar March 1–3 in Kohler

Wisconsin Chapter of the American College of Physicians is sponsoring a legislative seminar March 1–3 at the American Club, Kohler. Internists and their spouses will meet with members of the legislative and regulatory branches of state government who will serve as faculty.

Because of the ever-increasing amount of legislation and regulation and the shifting of health states, physicians must become more aware of and involved in this process. Hence, this meeting is being conducted to enable physicians to continue to establish avenues of communication and develop skills necessary to work with the legislative, executive, and regulatory branches of government.

Registration is from 4:00 to 6:00 pm Friday, March 1. The seminar will open with a reception and dinner at 6:00 pm followed by a brief orientation. On Saturday there will be several simultaneous small group sessions from 8:30 am to 4:00 pm and again on Sunday from 8:30 am until 10:00 am. A plenary session between 10:30 am and noon Sunday will close the seminar.

The workshop sessions include spouses and will be very informal and unstructured. Some of the topics expected to be discussed include:

—How the legislative, executive, and regulatory branches of Wisconsin government work and function.
—How interest groups best have input into the government process.
—How a bill is initiated, developed, and finally brought to a vote in the Legislature.
—How government agencies develop and implement regulations.
—Effect of shifts of responsibility to Wisconsin state government from the federal level.
—How legislation and regulation can be shaped in its development.

These workshops are designed to provide an atmosphere for free discussion and improved understanding of state government.

This seminar is not intended to be a forum for participants to promote any particular interests. Rather, the internists' purpose is to prove an opportunity to learn how state government works—a matter of vital interest to a well-informed leadership in the medical community.

Physicians desiring to attend should contact Edwin L Overholt, MD, FACP, Gundersen Clinic Ltd, 1836 South Ave, La Crosse, Wis 54601 at 608/782-7300, ext 2281.

Wisconsin Chapter, American College of Physicians at its meeting in September 1984 re-elected Edwin L Overholt, MD,* La Crosse as its president. Other officers are: Mahendra S Kochar, MD,* Wood, vice president; Thomas F Nikolai, MD,* Marshfield, secretary; and Terrence W Boland, MD, Onalaska, treasurer. ■

Burlington Memorial's Hospital medical staff recently elected Gerry K Larmore, MD,* Burlington, its chief-of-staff for 1985. Doctor Larmore succeeds Paul F Wagner, MD,* of Burlington. Doctor Larmore has been on the medical staff of Burlington Memorial since 1978.

St Luke's Hospital and Medical Dental Staff, Racine, has elected the following physicians as executive officers of its staff. Charles W Christenson, MD,* was elected chief-of-staff; Joseph R Wilczynski, MD,* vice chief-of-staff; Paul L Miller, MD,* secretary; and Jose E Reyes, MD,* treasurer. Other elected executive medical staff committee members are MDs William H Stone,* medical; Dennis J Kontra,* surgical; David R LeCloux,* Ob/Gyn; Stanley M Englander,* pediatrics; Ralph E Tomkiewicz,* psychiatry; Gerald J Sampica,* family practice; and Joseph R Wilczynski,* quality assurance.

Mercy Medical Center's medical staff in Oshkosh, has elected Eric B Wilson, MD,* as its chief-of-staff. Doctor Wilson, who has been director of Mercy's Medical Imaging since 1976, served as vice chief-of-staff this past year. A member of the board of directors of the Wisconsin Radiology Society since 1982, Doctor Wilson is currently serving a three-year term of office as secretary-treasurer. Also elected to the medical staff executive committee were: MDs James L Basiliere,* vice chief-of-staff; Paul C O'Connor,* secretary of staff; John B Andrew, immediate past chief-of-staff; and Robert J Greischar, Lance E Zernzach,* Warren V Hahn,* and Michael A Duffy,* members-at-large. ■

Richard D Kennedy, MD, 45, Eau Claire, died Oct 24, 1984 in Eau Claire. Born Mar 30, 1939 in Chicago, Ill, Doctor Kennedy graduated from the University of Minnesota School of Medicine and served his internship at University of Utah Hospitals. His residency, in orthopedic surgery, was completed at the University of Minnesota Hospitals. He was a member of the Eau Claire-Dunn-Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Sandra; two sons, Richard and Charles; and five daughters, Sarah, Ann, Margaret, Kathryn, Elizabeth; and two stepchildren, Molly and Eric.

Albert M Cohen, MD, 57, Fox Point, died Oct 26, 1984 in Milwaukee. Born Apr 9, 1927 in Milwaukee, Doctor Cohen graduated from the Marquette University School of Medicine in 1954 and completed his internship at Mt Sinai Hospital, Milwaukee. His residency was served at the Veterans Administration Hospital, Wood. Doctor Cohen served in the United States Army from 1945-1947. He was an associate clinical professor of physical medicine at the Medical College of Wisconsin, Milwaukee. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Bernice; two daughters, Mrs Simon (Sandra) Margulius, Bayside; Marla S, Milwaukee; three sons, Joel M Cohen, MD, Madison; Gary A Cohen, MD, Glendale; and David Brian Cohen, Madison. Also surviving are four grandchildren.

Alphonsus M Rauch, MD, 84, formerly of Kenosha and Lake Geneva, died Oct 26, 1984 in West Bend. Born Jan 31, 1900 in Chilton, Doctor Rauch graduated from the Marquette University School of Medicine and served his internship at Milwaukee County General Hospital. Doctor Rauch practiced medicine in Kenosha from 1929-1960 when he moved to Lake Geneva. He served on the medical staff of St Catherine's and Kenosha Memorial hospitals and also was chief-of-staff at both hospitals. He was chairman of the Walworth County Nutrition Council and also supervised the Blood Bank in Lake Geneva for many years. He was on the medical staff at New York Lying-In Hospital for six months, and was in general practice with J F Bennett, MD in Burlington, Wis. He was a member of the Walworth County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Jane; and two daughters, Alice Bates, West Bend, and Janet Lee Keck of Elmhurst, Ill.

Robert B Andrew, MD, 50, Madison, died Oct 31, 1984 in a plane crash near North Freedom. Born July 13, 1934 in Detroit, Mich, Doctor Andrew graduated from the University of Michigan Medical School, Ann Arbor, and served his internship at the United States Naval Hospital in Chelsea, Mass. His residency was completed at Wayne State University, Detroit, Mich. He was a fellow of the American Academy of Ophthalmology and had served on the medical staffs of Madison General, St Marys, Methodist, Divine Savior, Portage, Reedsburg Memorial and St Joseph hospitals. He served in mission hospitals in Mungeli, Balaspur, and in Punjab, India. He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Irmgard; three daughters, Mrs Rebecca Spear, Chicago; Mrs Sarah Frykenberg, Boston, Mass; and Jennifer, Madison; two sons, Miles and Nathan of Madison; and two grandchildren, Erin and Benjamin Spear of Chicago.

Christian Fredrik Midelfort, MD, 78, La Crosse, died Nov 4, 1984 in La Crosse. Born Oct 23, 1906 in Eau Claire, Doctor Midelfort graduated from Johns Hopkins Medical School in 1931 and served his internships at Peter Bent Brigham Hospital, Boston, and at New York City Hospital. His residency was completed at Wisconsin General Hospital (now UW Hospital and Clinics), Madison, Boston City Hospital, and Payne Whitney Psychiatric Clinic in New York City. Doctor Midelfort had been associated with the Gundersen Clinic Ltd, La Crosse, from 1944 until he retired in 1971. After his retirement, Doctor Midelfort taught family therapy one day a week at Lutheran General Hospital, Park Ridge, Ill, and at Lutheran Theological Seminary in St Paul, Minn. He had served as an assistant professor of internal medicine at the University of Wisconsin Medical School, Madison, and was a charter member of the Family Therapy Association. He was a member and former president of the La Crosse County Medical Society, a member of the "50 Year Club" of the State Medical Society of Wisconsin, and a member of the American Medical Association. Surviving are his widow, Helga, and five children.■

PHYSICIANS EXCHANGE

Wanted—Qualified physician to practice emergency medicine in southeastern Wisconsin. Our group is small and flexible. Salary is negotiable. If interested, send CV to Associated Emergency Room Physicians, SC, 1131 Sherwood Lane, Caledonia, Wis 53108; ph 414/835-4489. p1-3/85

General Internist or Family Practice physician needed to join well established solo internist/family practitioner in a beautiful lake area community of 21,000. Offering competitive salary with fringe benefits. Send CV to R C Maniquiz, MD, 600 Bay St, Chippewa Falls, Wis 54729 or call 715/723-0211. 1tfn/85

Academic Internist to join expanding dynamic young Ambulatory Care Group at the Milwaukee Regional Medical Center. Responsibilities to include: primary patient care, resident/physician education, and employee health. Opportunities for program development, administration, research, and advancement in clinical faculty track. Send inquiries to Kenneth E Smith, MD, Director, Primary Care Clinic, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Equal opportunity/affirmative action employer M/F/H. 1-3/85

Internist/Gastroenterologist, Board eligible, Boston-trained specialist seeking practice opportunity anywhere in Wisconsin. Contact Dept 551 in care of the Journal. p1/85

Internal Medicine—Board certified or eligible, to join 17-physician multispecialty clinic with 7-physician internal medicine department. Located in beautiful Wisconsin lakeshore community of 35,000. Competitive salary, complete fringe benefits, generous vacation time. Send CV to: Administrator, Manitowoc Clinic, SC, PO Box 3008, Manitowoc, WI 54220. 1-5/85

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; e.g., copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Madison, Wisconsin. Experienced physician for ambulatory care center. Medic-East, first and only independent ACC in Madison. Now well established. Located in heart of Eastside of Madison. Applicants BC/BE demonstrated experience in primary care, well-developed communication skills. Competitive salary, excellent benefits, attractive practice setting. Contact David A Goodman, MD, Medic-East, 2810 E Washington, Madison, WI 53704; ph 608/244-1213. 1tfn/85

Family Practitioner, General Surgeon, Neurologist and Pediatrician/Central Wisconsin. Excellent opportunity for Board certified/eligible physician to join 26-physician multispecialty group. 180-bed modern hospital. Plentiful recreational, cultural, and educational opportunities. Unique, attractive financial arrangements. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481; ph 715/344-4120. 1tfn/85

Internists—BC/BE Internist needed to join five general internists in multispecialty group practice in north-central Wisconsin. Competitive salary and benefits. General medicine training required. Cosmopolitan community and excellent recreational area. Send CV to D K Augenbaugh, MD, 2727 Plaza Dr, Wausau, WI 54401; or phone 715/847-3328. 1tfn/85

Family Practitioner wanted to join group of Boarded Family Practitioners, practicing real family medicine with full hospital privileges. HMO setting in Metropolitan Milwaukee. Very competitive salary and benefits. Please reply: James Chaillet, MD, Medical Director, Family Health Plan, 12500 W Bluemound Rd, Elm Grove, WI 53122; ph 414/786-3338, ext 451. 1-2/85

Primary Care—Union Grove Opportunity. Physician with background in general practice, pediatrics or internal medicine sought for full-time position with Department of Health and Social Services at Southern Wisconsin Center. This State facility, 20 miles south of Milwaukee, is engaged in the care of the developmentally disabled. Contact John F Brown, MD, Medical Director, c/o Southern Wisconsin Center, 21425 Spring St, Union Grove, WI 53182; ph 414/878-2411, ext 362. 11-12/84;1/85

Family Practice physician MD or DO Board eligible or certified. Contact Leon Gilman, 4957 West Fond du Lac Ave, Milwaukee, Wi 53216 or call 414/871-7900. 1-3/85

Family Practice opportunities exist with several expanding Marshfield Clinic, hospital-affiliated satellites in north central Wisconsin. The Board certified/Board eligible candidate will share the philosophy of oriented care with a preventive focus, enjoy the support of over 200 physician and surgeon specialists, and live at the doorstep of year-round recreational activities. Marshfield Clinic offers an excellent salary and benefit program including a liberal vacation and education leave. Please send curriculum vitae to: John P Folz, Assistant Director, 1000 North Oak, Marshfield, Wisconsin 54449. 12/84;2/85

Pediatrician needed by Marshfield Clinic to join primary care satellite in Ladysmith, Wisconsin. Current Ladysmith staff includes five family practitioners, four internists, one general surgeon, and a radiologist. An obstetrician will be joining the group in 1985. Clinic adjoins 41-bed JCAH-accredited hospital. Rural location in beautiful northern Wisconsin. Must be Board eligible or certified. Send curriculum vitae to Dr John Ziemer, 906 College Avenue West, Ladysmith, Wisconsin 54848, or call 715/532-6651. 1-2/85

Family Practice position available at Stanley, Wisconsin. This physician would join an existing family practitioner in a hospital-affiliated satellite center of Marshfield Clinic, a major multispecialty referral center. The ideal candidate would enjoy practicing a full medical spectrum including obstetrics and pediatrics, would enjoy working in a modern clinic facility that is physically attached to a 41-bed community hospital, and would enjoy living in a small rural community only 30 minutes from Wisconsin's fastest growing metropolitan area that contains a major University of Wisconsin campus. This opportunity offers a $63 thousand starting salary plus an extensive fringe benefit program. Please send curriculum vitae with first letter to: John P Folz, Assistant Director, 1000 North Oak, Marshfield, Wisconsin 54449. 1/85;3/85

Obstetrician-Gynecologist, Board certified or eligible, to join 17-physician multispecialty clinic with two physician OB/GYN department. Located in a beautiful Wisconsin lakeshore community of 35,000. Competitive salary, complete fringe benefits, generous vacation time. Send CV to: Administrator, Manitowoc Clinic, SC, PO Box 3008, Manitowoc, WI 54220. 6-12/84;1-5/85

PHYSICIANS EXCHANGE

continued

Internal Medicine—Hospital-based private practice in small community near Eau Claire, Wisconsin. Involves critical care management. Hospital less than 20 years old, 86-bed nursing home attached. Call-sharing and guarantees provided. Affiliation with Marshfield Clinic. Two-hour drive to Minneapolis. Charles Nelson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 414/785-6500. p1-2/85

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

The Racine Medical Clinic, a progressive cluster corporation of 31 physicians is currently seeking an Obstetrician/Gynecologist physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 12tfn/84

US Air Force Medical Corps currently is accepting applicants for physicians in the following specialties: Orthopedic; Ear, Nose and Throat; Obstetrics/Gynecology; General Surgeons; Family Practitioners; Internal Medicine and Pediatrics. For more information, call collect Capt Robb Sealey, 414/258-2430. 12/84;1/85

General Surgery Residency Program Director needed by 210 physician multispecialty private group practice in central Wisconsin. Board certified general surgeon with subspecialty training and interest in peripheral vascular surgery plus strong academic interests are being considered. This surgeon would join a seven-member General Surgery Section with subspecialty expertise and experience. A clinical appointment through the University of Wisconsin Medical School is available as are research opportunities. Please call Gail H Williams, MD, Surgery Department Chairman, or Sidney E Johnson, MD, Medical Director collect at (715) 387-5609 and (715) 387-5253 respectively or send curriculum vitae to: Gail H Williams, MD, Chairman, Department of Surgery, Marshfield Clinic, Marshfield, WI 54449. 11-12/84;1/85

Family Practice Oconto Falls, Wisconsin. Thirty miles northwest of Green Bay. Established practitioner needs associate to share fully-equipped clinic adjacent to 50-bed hospital. Income guaranteed by hospital. No ER call required. Abundant hunting, fishing, recreational opportunities. Contact Brett Wilson, DO, 835 S Main St, Oconto Falls, Wisconsin 54154 or call 1-800/242-4414, ext 278 or 414/846-2287. 11tfn/84

The Racine Medical Clinic, a progressive cluster corporation of 31 physicians is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 12tfn/84

14 MD multispecialty clinic wishes to add third OB/GYN 7/1/85. Three progressive hospitals (regional referral center for Maternal High Risk); ultrasound, office cytoscopy, colposcopy, laser, hysteroscopy, etc; no abortions. Competitive salary and benefits leading to partnership in two years. Excellent family community with multiple recreational and cultural activities available. Send CV to T E Flood, Administrator, Beaumont Clinic, Ltd, 1821 S Webster Ave, Green Bay, WI 54301. p12/84;1-3/85

Medical Director. Opportunity for physician with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; ph 608/251-4156. 6tfn/84

Family Practice. Rapidly expanding staff model HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; ph 608/251-4156. 6tfn/84

Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. 6tfn/84;c10tfn/84

Family Physician, Board certified or eligible, to join small group as third FP. East Central Wisconsin. Salary plus production bonus. Option for full partnership after one year. Well established practice, includes OB, Pediatrics, Geriatrics,. Please contact McCullough & Devine Clinic, SC, 105 Sheboygan St, Fond du Lac, WI 54935; ph 414/921-8110. 10-12/84;1/85

Family Practice physician needed to join five family practitioners and a general surgeon. Immediate opportunity in west central Wisconsin near La Crosse. $45,000 first year guarantee plus incentive. Excellent recreational area. Community Hospital. Send CV to: Jerrold L Kamp, Administrator, PO Box 250, Sparta, WI 54656; or phone 608/269-6731. 6tfn/84

Wisconsin, Milwaukee: Immediate opening for a full-time emergency physician in a 350-bed suburban community hospital. Experience or residency training required. Excellent working relationship with administration, medical, and nursing staff. Competitive salary with paid malpractice, life, health, and disability insurance, plus retirement plan. Send CV to Landy Bonelli, MD, Emergency Physicians WAMH, Ltd, 10201 W Lincoln Ave, Ste 304, West Allis, WI 53227; 414/545-5566. 12/84;1/85

Family Practice/Sports Medicine physician immediately needed. Excellent compensation in rapidly growing health group. Part-time or full-time career opportunity. Call Linda Gaioni, Racine, Wis. Area code 414/886-5588. 12/84*

General surgeon, OB/GYN, and internist to join seven-doctor family practice clinic in Cloquet, Minnesota, a community of 14,000 (30,000) service area, located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped, 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally our community is noted for its excellent school system. First-year salary guarantee; paid malpractice, health, and disability insurance; vacation and study time. Contact John Turonie, Administrator, Raiter Clinic Ltd, 417 Skyline Blvd, Cloquet, Minnesota 55720. Telephone 218/879-1271. *10-12/84;1/85

PHYSICIANS EXCHANGE

continued

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 10-12/84;1-3/85

Group Health, Inc, the midwest's largest and oldest prepaid multispecialty group, seeks associates in *Allergy, Family Practice (urgent care), Internal Medicine, Geriatrics, Ophthalmology, Child Psychiatry,* and *Obstetrics/Gynecology.* Must be Board certified or eligible. Excellent facilities, comprehensive fringe benefits, highly competitive earnings. Send curriculum vitae to: Paul J Brat, MD, Medical Director, Group Health Inc, 2829 University Avenue Southeast, Minneapolis, Minnesota 55414. An equal opportunity employer. 12/84;1/85

Expanding Ambulatory Care Center Network seeks top quality Family Practice, Internal Medicine or Primary Care physicians. Full-time and some part-time positions available in major cities in Ohio and Wisconsin. Competitive salary with excellent benefit package including malpractice insurance, health and life insurance, paid vacations, educational and assistance and flexible hours with no night duty. Send CV to: Jeannine Smeltzer, MED/ACCESS, Suite 13, 3085 West Market St, Akron, Ohio 44313 or call 216/867-2192. g11-12/84;1/85

Wanted: Young Family Practitioner to join a ten-physician group in western Wisconsin. Contact R M Hammer, MD, River Falls, Wisconsin 54022; ph 612/436-8809 or 715/425-6701. 8tfn/84

Internist, with or without subspecialty, and an OB/GYN needed (Board certified or eligible) to practice in conjunction with a 7-member Internal Medicine Department and a 5-member OB/GYN Department in a 24-member multispecialty group. The Internal Medicine Department currently has subspecialties in gastroenterology, pulmonary medicine, and cardiology. The Group is located in Southeastern Wisconsin in a city of 100,000, between two major metropolitan areas of greater than one million. Estimated service area is approximately 200,000. If interested, please send CV to Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential and additional information will be sent. 7tfn/84

Board eligible cardiologist interested in establishing an invasive service in a north central metropolitan, university-affiliated hospital in association with an internists' group needed. Interest in internal medicine necessary. Contact Dept 546 in care of the Journal. 10-12/84;1/85

Family Practitioners, Pediatricians, Orthopedic Surgeons, and OB/GYNs. Looking for qualified people in these areas of medicine. Located in a prosperous community in SE Wisconsin close to Milwaukee, Madison, and Chicago. I can offer pleasant surroundings, competitive salary, benefits, and fully-staffed office all within a newly decorated office. Write or call Medical Consultants, SC, 137 W Chestnut, Burlington, WI 53105; ph 414/763-3531. 12/84;1-2/85

Family Practitioner. Rural Wisconsin community, population 3500 with service area of 8500, seeking additional family practitioner. Fifteen minutes from State Capitol with readily available tertiary medical support. Family practice department in multispecialty clinic. Excellent fringe benefits and salary. Attractive working conditions and environment. Interested parties should contact Dept 550 in care of the Journal. 12/84;1-2/85

PHYSICIANS WANTED

Full or part-time PHYSICIANS WANTED for emergency room work throughout Wisconsin. National Emergency Services offers excellent income, paid malpractice insurance, and flexible scheduling. If you're interested in exploring opportunities with N E S and you would like additional information, call Timothy Molyneux or James Lucas at 1-800/537-3355. 12/84;1/85

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

Wisconsin—Established FFS corporation seeking Board-prepared/certified emergency physicians for community hospital in southeast Wisconsin. Directorship available to qualified candidate. Send CV to Emergency Physicians Group, 430 Milwaukee Ave, Prairie View, IL 60069. Contact Ms Barbara LaPiana, 312/634-4640. 11tfn/84

Immediate opportunities for qualified physicians who possess excellent clinical and communication skills to join longstanding group of Emergency Physicians. Positions available in a popular Wisconsin area bordering Illinois. If interested, send resume to Barbara Wilczynski, Medical Emergency, Service Associates

Wanted: Wisconsin Licensed Physicians to assist in adjudicating Social Security Disability claims at the Bureau of Social Security Disability Insurance. Work part-time (20-35 hours/week). If interested, write or telephone George H Handy, MD, PO Box 7623, Madison, Wisconsin 53707; ph 608/266-1989. 11-12/84;1/85

FAMILY PRACTITIONERS INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone: 608/263-4095 7/84;6/85

PHYSICIANS EXCHANGE

continued

(MESA), SC, 15 S McHenry Road, Suite 2, Buffalo Grove, IL 60090 or call collect 312/459-7304. 6tfn/83

MEDICAL FACILITIES

Family Practice for sale in Milwaukee. Ideal starter or satellite office. Excellent patient goodwill. Fully equipped and furnished three examining rooms, waiting room, and office. Approximately 900 sq ft. Contact Greg Rodenbeck, DDS, 1200 E Oklahoma Ave, Milwaukee, Wis 53207; 414/481-8111. g10tfn/84

Family Practice for sale Waukesha area. Completely equipped with x-ray, laboratory in two-person office. Very favorable lease. Office fully-staffed and expenses shared with another family physician. Retiring July 1, 1985. Gross over $200,000. Will introduce. Contact Dept 548 in care of the Journal. 11-12/84;1/85

Office for subleasing. Attractive, newly decorated 1,800 square feet of office space in a very desirable location at 811 East Wisconsin Avenue, Milwaukee. Currently set up for practice of Internal Medicine. Ideal for starting a practice or satellite office. Would consider leasing furnishings and equipment. Call 414/278-7144. 12/84;1-2/85

ANNOUNCEMENTS

Administrative Medicine. Summer institute for graduate education in administration for physicians and other clinicians with managerial responsibilities. June 16–July 6, 1985. University of Wisconsin-Madison Medical School, Department of Preventive Medicine, 1225 Observatory Drive, Madison, Wis 53706. Application deadline: February 15.

The State Laboratory of Hygiene announced that a complete listing of all procedures in the clinical environmental and industrial hygiene areas is now available upon request. Wisconsin physicians, hospitals, clinics as well as local public health and environmental agencies may use the Laboratory's services. Telephone (608) 262-1293 for a copy. g11/84 ■

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Professionals Insurance Company, The 58
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Dalmane®
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Upjohn Company, The 35
Motrin®
Winthrop Breon Laboratories 9, 10
Talwin® Nx
WISPAC . . . . . 18 ■

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Learning To Live With Diabetes. Medicine In the Public Interest, Inc, 65 Franklin St, #304, Boston, MA 02110. 1984. Pp 87.

Report of The Council for Tobacco Research—USA, Inc. The Council for Tobacco Research—USA, Inc, 900 Third Ave, New York, NY 10022. 1984. Pp 146.

Treating Type A Behavior and Your Heart. By Meyer Friedman, MD, and Diane Ulmer, RN, MS. Alfred A Knopf Publishing Co, New York. 1984. Pp 285. Price: $15.95.

Hynotherapy of Pain in Children with Cancer. By Josephine R Hilgard & Samuel LeBaron. William Kaufmann, Inc, 95 First St, Los Altos, CA 94022. 1984. Pp 250. Price: $18.95. ■

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

JANUARY 30–FEBRUARY 1, 1985: *15th Annual Winter Refresher Course for Family Physicians,* at Pfister Hotel and Tower, Milwaukee. Sponsored by Department of Family Practice, Medical College of Wisconsin and Southeast Chapter of Wisconsin Academy of Family Physicians. Three-day program includes lectures and workshops for family physicians in active practice to provide current information on major disciplines in medicine. Fee: $200. Info: Mrs Susanna Raechlitz, Conference Manager, Department of Family Practice, 1315 North 74th St, Wauwatosa, Wis 53213; ph 414/778-3820. 12/84;1/85

FEBRUARY 12–14, 1985: *Telemark Symposium and Ski Outing (22nd Annual),* Telemark Lodge, Cable, Wisconsin. Sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians. Info: WAFP, 850 Elm Grove Road, Elm Grove, WI 53122; ph 414/784-3656. 12/84;1/85

FEBRUARY 13–15, 1985: *Midwinter Medical Conference* at Ski Brule. Sponsored by West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Phone 414/494-5611 for details. 1/85

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE tor listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the July 6, 1984 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period September 1984 through February 1985.

MARCH 1–3, 1985: Wisconsin Psychiatric Association at Lake Lawn Lodge, Delavan. g11-12/84;1-2/85

APRIL 19–20, 1985: Wisconsin Urological Society, Pfister Hotel, Milwaukee. g11tfn/84

APRIL or MAY 1985: Wisconsin Association of Medical Directors *Annual Meeting* (in conjunction with the County Homes Association), tentatively at Stevens Point. More definite details to come. g12/84

MAY 9–11, 1985: Wisconsin Chapter, American Academy of Pediatrics, Pioneer Inn, Oshkosh. g11tfn/84

JUNE 12–15, 1985: *37th Annual Scientific Assembly of the Wisconsin Academy of Family Physicians,* Americana Resort Hotel, Lake Geneva, Wisconsin. Info: WAFP, 850 Elm Grove Road, Elm Grove, WI 53122; ph 414/784-3656. 12/84;1-5/85

State Medical Society of Wisconsin
Dates and locations of ANNUAL MEETINGS 1985–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the La Crosse Convention Center.

1985—April 25–27
1986—April 17–19
1987—March 26–28
1988—April 28–30
1989—April 13–15
1990—April 26–28
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

OTHERS

MARCH 1–3, 1985 (Illinois): *Midwest Clinical Conference,* sponsored by Chicago Medical Society, at Westin Hotel, Chicago. Info: Chicago Medical Society, 515 North Dearborn St, Chicago, Ill 60610; ph 312/670-2550. gl-2/85

MARCH 4–15, 1985 (Florida): *Practical Update for Primary Care Physicians,* MEDICLINICS postgraduate medical refresher course, Fort Lauderdale. 50 Category I credit hours. Limited one week, 25-hour credit course available. Preregistration: $450 (until Feb 15, 1985). Info: Mediclinics, 2917 South Ocean Blvd, Suite 905, Highland Beach, Florida 33431; or phone 305/272-8973. 12/84;1/85

MARCH 20, 1985 (Illinois): *Trends in Specialization: Tomorrow's Medicine,* at

Wisconsin Specialty Society Meetings

- Wisconsin Psychiatric Association, March 1–3, 1985, Lake Lawn Lodge, Delevan
- Wisconsin Urological Society, April 19–20, 1985, Pfister Hotel, Milwaukee
- Wisconsin Chapter: American Academy of Pediatrics, May 9–11, 1985, Pioneer Inn, Oshkosh
- Wisconsin Academy of Family Physicians, June 12–15, 1985, Americana Resort, Lake Geneva

***

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 25–27, 1985, La Crosse

- Wisconsin Society of Anesthesiologists
- Wisconsin Dermatological Society
- Wisconsin Chapter, American College of Emergency Physicians
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Internal Medicine
- Wisconsin Academy of Ophthalmology
- Wisconsin Otolaryngological Society
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine & Rehabilitation
- Wisconsin Society of Plastic Surgeons
- Wisconsin Society for Preventive Medicine
- Wisconsin Society of Radiation Oncologists
- Wisconsin Surgical Society

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

Westin Hotel O'Hare, Chicago. Jointly sponsored by the American Board of Medical Specialties and the Royal College of Physicians and Surgeons of Canada. Info: American Board of Medical Specialties, One American Plaza, Suite 805, Evanston, IL 60201; phone 312/491-9091.
g12/84;1-2/85

APRIL 10–14, 1985 (Florida): *20th Annual Clinical Conference* at Longboat Key Club, Longboat Key. Sponsored by the Marquette-MCW Medical Alumni Association and the Medical College of Wisconsin. Info: Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226; ph 414/257-8367. 1-3/85

AUGUST 1–4, 1985 (Georgia): *International Doctors in Alcoholics Anonymous Annual Meeting.* Hyatt Regency Hotel, Savannah. Reservations may be made at a later date when specific details and instructions are published. For further information contact: Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44511; ph 216/782-6216. g12tfn/84

SEPTEMBER 17–18, 1985 (Illinois): *Medical Practice and Hospital Privileges,* at Chicago Marriott O'Hare, Chicago. Info: American Board of Medical Specialties, One American Plaza, Suite 805, Evanston, IL 60201; phone 312/491-9091.
g12/84;1-8/85

1985 CME Cruise/Conferences on Selected Medical Topics—Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20-24 CME Category I credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. ***Fly roundtrip free on Caribbean, Mexican, & Alaskan Cruises.*** Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Info: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 516/549-0869.
p9-11/84;1,3,4/85

AMA

JUNE 16–20, 1985: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 8–11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

Consensus Development Conference

Electroconvulsive Therapy

June 10–12, 1985
Masur Auditorium, Warren Grant Magnuson Clinical Center, National Institutes of Health, 9000 Rockville Pike

Bethesda, Maryland

Sponsored by the National Institute of Mental Health and the Office of Medical Applications of Research, National Institutes of Health

This open forum will address the use of electroconvulsive therapy (ECT) in the treatment of the severely mentally ill.

During the 45 years ECT has been in use, concern has been shown by practitioners, patients, and the public about whether, when, how, and for whom to use ECT and about possible long-term side effects. In recent years scientists have conducted intensified studies on clarifying mechanisms of action; determining optimum mode of administration; establishing the extent of adverse effects, particularly on brain functioning and memory; and evaluating effectiveness in a variety of mental disorders. These endeavors have produced a substantial data base relevant to the effectiveness and safety of ECT.

Following 1½ days of presentations by experts in the relevant fields, a consensus panel consisting of representatives from psychiatry, psychology, neurology, epidemiology, and the public will consider the scientific evidence and formulate a consensus state-

continued next column

continued

ment responding to the following key questions:

- What is the evidence that ECT is effective for patients with specific mental disorders?
- What are the risks and adverse effects of ECT?
- What factors should be considered by the physician and patient in determining if and when ECT would be an appropriate treatment?
- How should ECT be administered to maximize benefits and minimize risks?
- What are the directions for future use?

NIH consensus conferences bring together biomedical investigators, practicing physicians, consumers, and representatives of public interest groups to review scientific information and evaluate the safety and effectiveness of selected drugs, devices, and procedures.

To register for this conference or to obtain further information, contact: Ms Michele Dillon, Prospect Associates, Suite 401, 2115 East Jefferson St, Rockville, Md 20852; ph 301/468-6555.

FOR PROGRAM INFORMATION, contact: Jack D Blaine, MD, Affective Disorders Section, Pharmacologic and Somatic Treatments Research Branch, National Institute of Mental Health, Parklawn Bldg, Room 10C06, 5600 Fishers Lane, Rockville, Md 20857; ph 301/443-3568.

International Childbirth Education Association

to host 1985 Conference

in cooperation with Methodist Hospital who will coordinate the local planning committee.

in Madison, June 20–23

at the Sheraton Inn and Conference Center

The four-day conference is expected to draw 400 to 500 persons from across the nation, including childbirth educators, nurses, physicians, parent advocates, and others interested in the current changes in pregnancy, birthing, and early parenting.

Persons interested in assisting with the conference or learning more details can call Methodist Hospital, Madison, at 608/258-3290.

LET THESE GUIDES HELP YOU

THE FOLLOWING GUIDES and manuals have been prepared or obtained at the direction of the Board of Directors and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept., State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.
- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.
- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.
- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Revised 1978—Single copy 25¢ with order.)
- **If You Have a Complaint About Medical Care**—Medical care is a personal matter between patient and physician. Yet, sometimes misunderstandings arise about what the physician hopes to accomplish and what the patient expects. This brochure, aimed at patients, explains the State Medical Society's grievance and peer review system.
- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $2.00 plus 5% sales tax with order.)
- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10″x11½″. For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $11.00; complete guide without binder: $10.00—to accompany order.)
- **Make Yours a Smokeless Pregnancy**—Points out the dangers of smoking during pregnancy and its effects on the fetus.
- **Retention and inspection of patients' records**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.
- **Legal Responsibilities of the Physician-Patient Relationship**
- **Putting the UCR Fee Puzzle Together**—Explains what "usual, customary and reasonable" means, how misunderstandings concerning it can be avoided and how problems can be resolved when they occur. The small size of the brochure makes it suitable for enclosure in office statements or for placement in patient reception areas.
- **Guide to the Service Corporation Law**
- **Some Straight 'Dope' on Marijuana**—Increasing evidence appearing regularly that marijuana is hazardous to health has led the State Medical Society of Wisconsin to declare it to be a dangerous drug. This brochure explains what marijuana is, who uses it, and points out some of the psychological and physiological hazards associated with its use.
- **Rubella—Red Measles Brochure**—This conveniently sized 2½″x4″ sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.
- **Getting the Most Out of Your Health Care Dollar**—Explains the reasons for rising health care costs and offers advice on what the patient can do to control them.
- **Alcohol and Your Unborn Baby . . .**—Warns women of the harmful effects alcohol can have on an unborn child. Available in both English and Spanish versions.
- **To All My Patients, Partners in Good Health**—Explains the rights and responsibilities physicians and patients have in medical care. Available in standard brochure or smaller "statement stuffer" form.
- **I Want To Know What You Think**—a questionnaire physicians can use with patients to elicit their attitudes and opinions regarding his/her medical practice.
- **So You've Been Sued . . . Now What?**—a brochure prepared by the SMS Medical Liability Committee which answers 12 questions physicians commonly ask about medical malpractice lawsuits.

Interim recommendations issued on DPT shortage. The Centers for Disease Control has announced that a shortage of diphtheria-pertussis-tetanus (DPT) vaccine exists in the US. The shortage has occurred because all manufacturers, except one, have stopped producing the vaccine due to prohibitive product liability costs. That manufacturer recently experienced production difficulties and said no new vaccine lots will be available until sometime in February 1985. Litigation costs have been high since rare, but severe reactions include brain damage and death. After consultation with members of the Centers for Disease Control's Immunization Practices Advisory Committee and the Committee on Infectious Diseases of the American Academy of Pediatrics, the US Surgeon General has issued the following interim recommendations:

1. ***Effective immediately,*** all healthcare providers should postpone administration of the DPT vaccine doses usually given at 18 months and 4-6 years of age (fourth and fifth doses) until greater supplies are available.
2. When adequate DPT vaccine becomes available, steps should be taken to recall all children under 7 years of age who miss these doses for remedial immunization.

If these recommendations are followed by all providers of DPT vaccine throughout this temporary vaccine shortage, immunity in infants will be maintained at the best possible levels. Public healthcare providers and professional organizations throughout the United States have been notified and are being urged to follow these recommendations.

The American Medical Association's Ad Hoc Commission on Vaccine Injury Compensation has been monitoring the shortage situation and has issued the following statement: "The Centers for Disease Control announcement of a shortage of DPT vaccine underscores the vital need for federal legislation aimed at protecting vaccine supplies." AMA Ad Hoc Commission Chairman Alan R Nelson, MD summarized the Commission's recommendation as follows:

- The benefits of vaccination outweigh the risks.
- Federal legislation should provide no-fault review of injury claims. While few people are injured, those who are should be compensated by the federal government.

Nelson added that because of concern over the supply of DPT vaccine, legislative action is needed to protect vaccine manufacturers from product liability action. At the same time, the federal government should be allowed to recover costs of compensation to injured patients, if negligence is proven. "In addition," Nelson said, "we need to encourage continued research to improve the vaccine." ■

Chelation therapy: AMA policy statement. The AMA House of Delegates at its December 1984 session adopted the following policy statement on this controversial treatment: *Resolved,* That AMA reports show that there is no scientific documentation that the use of chelation therapy is effective in the treatment of cardiovascular disease, atherosclerosis, rheumatoid arthritis, and cancer; and be it further *Resolved,* That if chelation therapy is to be considered a useful medical treatment for anything other than heavy metal poisoning, hypercalcemia, or digitalis toxicity, it is the responsibility of its proponents to (a) conduct properly controlled scientific studies, (b) adhere to FDA guidelines for the investigation of drugs, and (c) disseminate results of scientific studies in the usually accepted channels. ■

Physicians must report child abuse and neglect. Physicians and others dealing with children are mandated by law to report cases of suspected child abuse. Abuse includes repeated beatings or other forms of severe abuse, sexual exploitation, physical crippling, brain damage, or even death. Threat of injury and emotional damage to a child also is considered abuse under the law. Child abuse is a felony punishable by a fine up to $10,000 and imprisonment up to two years. Because of current attention being focused on the problems of child abuse in its various dimensions, the State Medical Society is preparing a series of articles for publication in the *WMJ* to aid physicians in their response to situations of child abuse. The first article, *Child abuse and neglect: Diagnostic and treatment guidelines,* appears in this issue. Subsequent articles will focus on the legal, societal, and ethical issues involved in child abuse. ■

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References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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WISCONSIN MEDICAL JOURNAL

Medical alert—DES exposure. Society urges physicians to take precautionary measures to help patients and their DES-exposed offspring become aware of the need to be examined and possibly treated for cervical or vaginal complications (see page 11).

Child abuse and neglect. An explanation and implication of the law—1973 Wisconsin Act 172 (see page 15).

Ethical decision-making in the care of seriously ill patients. Limitation of resources and concerns with the quality of human life have moved the ethical decision process into the center of medical practice (see page 25).

Nominees for SMS offices. Biographical sketches and pictures. Election April 26 at Annual Meeting in La Crosse (see page 40).

M. D. S.

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CONTENTS

February 1985

SPECIAL FEATURES

5 **President's Page:** Malpractice seizures, by *Timothy T Flaherty, MD,* Neenah

6 **Editorials:** Malpractice panels: Are they the solution?, by *Wayne J Boulanger, MD,* Milwaukee . . . Malpractice panels: The Society's view, by *Sidney E Johnson, MD,* Marshfield . . . What's your opinion? . . . DES—Forty years of fallout . . . Advertising, by *Victor S Falk, MD,* Edgerton . . . The spittoon bowl, by *Raymond A McCormick, MD,* Green Bay . . . I am sorry, Doctor, by *Victor S Falk, MD,* Edgerton

11 **Special:** Diethylstilbestrol (DES) update[1]—A message from the DESAD Project (Medical alert—DES exposure)

15 **Special:** Child abuse and neglect: The law—explanation and implication (1983 Wisconsin Act 172)

50 **Socioeconomics:** Reform malpractice system to cut costs, Medical Society tells Legislature . . . Uncompensated care problem looms on horizon, SMS President says . . .Malpractice committee backs SMS peer review proposal . . . WHCLIP Fund rate increases recommended . . . Medicare participating physicians' directories available . . . Legislative leadership announced

53 **WISPAC,** by *William L Treacy, MD,* Chairman, WISPAC Board of Directors

68 **Public health:** New Baby Doe rules proposed . . . SMS seeking repeal of rule allowing chiropractors to draw blood

84 **News you can use:** More physicians leaning towards advertising . . . Wisconsin ranks #17 in Medicare sign-up rate . . . Physicians to receive 3% increase in Medicaid reimbursement . . . CHAMPUS appoints new provider field rep for Wisconsin . . . Cancer Society launches education campaign on colorectal cancer

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84, No. 2

CONTENTS

STATE MEDICAL SOCIETY OF WISCONSIN

SCIENTIFIC MEDICINE

25 Ethical decision-making in the care of seriously ill patients, by *Guenther P Pohlmann, MD,* Milwaukee

32 Malignant mesothelioma, by *Warren H De Kraay, MD,* Kenosha

33 A survey showing current status of medical directors and long-term care facilities in Wisconsin (summary), by *Mary Ann Zilz, RN,* Madison

ORGANIZATIONAL

39 SMS Annual Meeting approaching . . . CES Foundation announces new research trust fund

40 ANNUAL MEETING: Nominees for SMS offices; election April 26 (biographical sketches with pictures)

43 ANNUAL MEETING: House of Delegates 1984–85 Nominating Committee

43 SMS needs MDs for committees, commissions

44 COUNTY MEDICAL SOCIETIES: List of officers with addresses and telephone numbers

47 Membership Directory—update

52 Annual Meeting resolution deadline

54 CES FOUNDATION: Contributions for December 1984

60 CES FOUNDATION: Contributions during 1984

DEPARTMENTS

54 OBITUARIES:
Harold D Rose, MD
Wood
Ralph George Burnett, MD
Kenosha
Bernard Anthony Trimborn, MD
Milwaukee
Oscar A Stiennon, MD
Green Bay
Raul M Lagman, MD
Cuba City

77 COUNTY SOCIETIES: Brown County residents give high marks to area medical care . . . Eau Claire-Dunn-Pepin . . . Jefferson . . . Outagamie . . . Marinette-Florence . . . Monroe . . . Winnebago

79 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Miscellaneous . . . Medical meetings—Continuing medical education . . . Advertisers ■

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5600 member physicians in Wisconsin, comprising 55 county medical societies and 25 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Malpractice seizures

THE SYMPTOMS became highly noticeable about 1975. Professional liability premiums inflated to double-digit rates overnight. Suits for malpractice increased. Claims were being won for $100,000 or more. Unheard of!

Insurance companies, beset with plummeting investment earnings, panicked. Some withdrew from the marketplace; others cancelled high-risk insureds; still others rejected potential new policyholders. Unable to buy insurance or unwilling to pay what they thought were "exorbitant" premiums, many physicians were unable to enter practice. A few refused to serve hospitalized patients except in emergency. The profession was in seizure.

Physicians, hospitals, lawyers, and insurers clamored for relief. In 1976 the Legislature acted to "reform" the system. It created WHCLIP, a Patients Compensation Fund, and the patients compensation panel system. The seizures subsided to an occasional twinge; but the treatment masked the basic causes of the problem.

Ten years have passed. The petit mal-practice seizures have returned, but now they exhibit grand mal symptoms. Medical liability protection is fully available, but premium costs will go up 70-160% for 1985 and are projected for almost 100% escalation for each of the next four years. The mathematics are frightening. Physicians who this year will have their premiums doubled to a range of from $4,500 to $52,000 simply cannot absorb annual increases of this nature. This is particularly so when office expense is expected to increase more than 20% over 1984, medical supplies overhead up 17-19% over last year, and other professional expense increases in excess of 9.5%.

Until the Legislature, physicians, attorneys, and citizens seriously consider major changes in the tort system, the malpractice seizures facing this state will continue.

Our Society has been working closely with a State Legislative Council Committee on a series of reforms, but they do not represent long-term solutions to the problem. They do, however, represent a first step and deserve prompt consideration by the Legislature.

These reforms include a $1,000,000 limit on awards per occurrence (or in the alternative, drastic limitations on pain and suffering awards as well as structured payout of all settlements or awards); a more restrictive discounted reserving system for the Fund; installment payment of Fund premiums; an appropriate sliding scale on contingency fees for attorneys; certificates of merit prior to filing a claim; surcharges on certain insured physicians and reporting of all paid claims and settlements to the Medical Examining Board for investigation and review, plus an expanded system of malpractice prevention.

At the same time work must begin immediately on a more permanent solution which inevitably involves some means of eliminating the Fund's open-ended obligation to finance future losses, an insuring mechanism which is currently unrestricted by any responsible limit and which is perceived by lawyers and public alike as the ultimate deep pocket.

The State Medical Society of Wisconsin is committed to a resolution of this serious problem. Please join us.■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

Malpractice panels: Are they the solution?

THERE HAS BEEN pressure, most of it from the trial lawyers, to alter or abolish the Patient Compensation Panels. Perhaps the time has come to go back over the nine years of their existence and estimate their worth.

In the beginning most of us physicians looked upon them as a major improvement, at least in principle; and although we grumbled a bit, we served as panel members when called. Perhaps we liked them even more than was justified because it seemed the lawyers didn't. Certainly we were piqued by the frequent disruptive delays and cancellations, but we considered them a necessary evil and assumed the Panels were infinitely better than the courts.

But are they really?

After all, why should medical malpractice suits be treated differently from other civil actions? Many good lawyers think they shouldn't be.

Do the Panels save time? Apparently. On the average, it takes 391 days to institute a panel hearing, whereas 655 days are required to convene a malpractice action in circuit court.

So what? Does the expenditure of an additional nine or ten months work to our disadvantage? Our experts seem to think so, in that insurance companies are more likely to want to settle because of the inflationary effects on awards which are increasing at a rapid rate.

Are the awards granted by the Panels more realistic than those determined by a jury? It's hard to say.

Are the Panels fair? The lawyers think not, because of the presence under the law of two physicians, and want one physician replaced by a public member. But fairness is not easy to define; the loser seldom believes he was dealt with fairly.

Attorneys from both sides have complained that the attorney-chairmen of the Panels are often inept in conducting the hearings because of lack of experience in medical malpractice cases. When that situation obtains, appeal is a virtual certainty. (Ten percent of panel cases are eventually carried to circuit court today.) The medical society would like to see the Panels conducted by retired judges.

How are the doctors doing? They win 70% of the time. But that means they lose 30% of the time, and that seems to be a high figure when you consider the increasing number of actions brought each year.

Do the Panels encourage frivolous suits? Possibly, because it is easier and less expensive to bring a case before a Panel than it is to take it to court.

So what is the score? The State Medical Society believes the panel system, although in need of minor revision, has been a positive force in the malpractice morass these nine years and wants to save it. My own view is that if I'm sued, I want to go to court and put my fate in the hands of a judge and jury.

—Wayne J Boulanger, MD, Milwaukee

Malpractice panels: The Society's view

ANY SYSTEM USED to decide medicolegal issues should be constantly evaluted by physicians. The system should be fair to patients and physicians, cost-effective, and should enhance, not hinder, medical care. The State Bar of Wisconsin has officially called for the repeal of the Wisconsin Patient Compensation Panels system; Doctor Boulanger and others are now apparently asking for the same. The State Medical Society feels it is premature to abandon a system that has basically been working well. Members of the State Medical Society should be channeling their energies into improving our current system rather than abandoning a system that is working.

It is evident that the disposition time of panel cases is shorter as compared to jury trials. In 1983 the median disposition time for panel cases was under one year; the median disposition time for non-auto personal injury cases was 438 days in Milwaukee County and 432 days for the remainder of the state. I believe the physician benefits from this shortened period.

A malpractice suit is a serious and devastating event in the personal and professional lives of respondent physicians. A recent survey of physicians[1] who were named in malpractice actions describes the psychological and physical symptoms developed by the respondents. These include anger, change in mood, inner tension, depression, frustration, irritability, insomnia, fatigue, difficulty concentrating, feelings of worthlessness, feelings of guilt, feelings of

[1]Charles SC, Wibert JR, Kennedy EC: Physicians' self-reports of reactions to malpractice litigation. *Am J Psychiat* 1984(Apr);141:4.

low self-esteem, indecision, decreased appetite, gastrointestinal symptoms, headache, and even suicidal ideation. A psychiatric analysis of the reported symptoms indicated the possible presence of a depressive disorder in 40% of the physicians. Another 20% have symptoms suggestive of a severe adjustment disorder. Approximately 8% noted the onset of physical illness, including myocardial infarction, angina pectoris, duodenal ulcer, hypertension, and irritable bowel syndrome. The authors noted that the prolonged stress, aggravated by the timespan from filing of the suit to settlement, was felt to be a major factor in physician impairment. All of the respondents in this survey won their cases in court. This is good evidence that even an unjustified suit causes significant stress.

Is the panel system fair to patients? If the patient loses at panel, he/she has a right to trial by jury at circuit court. The panel decisions are in favor of the patient 30% of the time. Whether they would do better in court is an open question. Whether the award is appropriate and how much of the award the patient receives after all expenses are paid, including attorney contingency fees, is an unknown question. The amount finally received by a patient in any given case and the percentage of the total award that goes to the patient are data that should be developed to help determine the fairness of the overall system.

The number of cases submitted to Panels has risen sharply from 12 in 1976 to 378 in 1983. Physicians have been successful in defending these cases 70% of the time. I do not know if physicians would win a greater percentage in circuit court. In 1983 thirty-five malpractice cases were appealed to circuit court after being heard at panel, and five trials were conducted. I am told that a panel hearing is cheaper than a circuit court trial. If that is true, the panel system is certainly cost-effective, and it reduces the overall dollars spent in malpractice litigation. Overall, 80%-90% of malpractice cases in Wisconsin are disposed at the panel level, either by settlement, dismissal, or hearing.

The panel system allows practicing physicians first-hand experience with this element of the medicolegal system. While physicians dislike time away from practice, last minute cancellations of the panel hearing, and reimbursement that does not cover the cost

What's your opinion?

Because of differing views concerning the Patients Compensation Panel system, the following questions have been developed by the Committee on Medical Liability in an effort to determine the opinion of the membership. You are invited to answer the following questions and mail to: Committee on Medical Liability, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701. Signature not necessary.

	YES	NO
1. Have you had personal experience with the Panels as:		
a. a respondent in a suit?	_____	_____
b. a Panel member?	_____	_____
c. an expert witness?	_____	_____
2. Have you had personal experience with the court system as:		
a. a defendant?	_____	_____
b. a juror?	_____	_____
c. an expert witness?	_____	_____
3. Do you favor continuation of the Panel system as it is now?	_____	_____
4. Do you favor having the Panel decision be final subject only to judicial review (or whether the Panel hearing was conducted in a legally proper manner)?	_____	_____
5. Do you favor amending the Panel law to allow direct access to circuit court if both parties agree to waive the Panel hearing?	_____	_____

7. Comments: _____

_____

_____

_____

(Further comment may be attached)

of being away from practice, this ever-growing collective experience of physicians gives us a unique opportunity to be educated about medicolegal issues. The State Medical Society might be wise to develop a program to collect and evaluate reports from physicians serving on Panels that would augment development of a risk-control program by Wisconsin physicians.

A worrisome trend may be the use of the panel system by plaintiffs and their attorneys as a stepping stone to trial in circuit court. The panel decision, however, is admissible in court and the State Medical Society should closely analyze the outcome of those cases heard at panel and later decided in a court of law. While I have no evidence at this time, it is my impression that if a plaintiff wins at panel, he/she is very likely to win in court.

A special Legislative Council committee on medical malpractice is currently reviewing approximately 60 proposals to modify the current system. This committee has drawn the ire of the trial lawyers with its recommendations to limit awards and limit contingency fees. Let us hope that the committee can recommend some needed improvements in the system that will benefit the citizens of the State of Wisconsin, including physicians, hospitals, and patients.

—*Sidney E Johnson, MD,* Marshfield
Member of the State Medical Society's Medical Liability Committee of the Physicians Alliance Division

DES—Forty years of fallout

DESPITE ALL the scientific literature, all the nationwide public education, and all the widely publicized litigation against manufacturers over the last 40 years, the use of DES (diethylstilbestrol) for women at risk of miscarriage, starting in the late 1940s and officially terminated in 1971, continues as a lingering concern for physicians and the public.

Even though the risk of development of clear cell cancer in daughters of DES users is estimated to be no more than 1.4 per 1000 and as few as 1.4 per 10,000, the possibility of cancer among those whose identity remains unknown is of deep concern to the potentially affected families. Adding to the suspense is the fact that the long-term effects on mothers, daughters, and sons is not firmly known.

The article, "Diethylstilbestrol (DES) update," in this issue is an excellent summary of the current status of this long-standing problem. It is further a reminder that the fallout from the innocent and nonnegligent use of DES at a time when it was *the* drug for problem pregnancies continues to require diligent search for daughters and sons of exposed women.

The State Medical Society's recent Medical Alert on DES was very frankly prompted by the fears of Laila Rosen, Milwaukee (Bayside), that her own recent discovery of DES exposure 17 years earlier might well apply to others. After *The Milwaukee Journal* carried her story, SMS confirmed the need for continued vigilance with the American Medical Association and its own Maternal and Child Health Committee. Credit is indeed due Mrs Rosen's determination and *The Milwaukee Journal's* nose for news; no less credit is due the State Medical Society for appropriately responding to a clear and timely need for patient advocacy.

Advertising

WHEN I FIRST joined the Editorial Board of the *Wisconsin Medical Journal* in 1953, the chief complaint of the Board members was that the *Journal* was overloaded with advertising. This contributed handsomely to the coffers of the State Medical Society, but it did detract somewhat from the *Journal.*

When the Kefauver legislation became effective a few years later, the *Journal* advertising dropped off drastically. Few new products were being introduced and many of the old ones were eliminated. A good many lean years followed, and the *Journal* required subsidization by the Society. Some of the weaker state journals folded.

Recently the staff of the *Journal* was contacted relative to publishing an ad from a Chicago helicopter service that would transport patients from southern Wisconsin to a Chicago hospital. Although this might irritate some Wisconsin physicians, it was felt that the ad could not be rejected since it might be regarded as a restraint of trade. Subsequently the *Journal* has published ads from hospitals located in bordering states. Since Wisconsin physicians are regularly flooded with mail from hospitals and clinics in that same area, it was felt that ads in the *Journal* would not result in any conflict of interest.

At the same time, we have learned that the national advertising for January 1985, originating from the State Medical Journal Advertising Bureau in Chicago, is three times as great as it was in January 1984. This is a very encouraging trend, and it's a great way to start the new year.

—*Victor S Falk, MD,* Edgerton

The spittoon bowl

AT THE END OF another football season, with all of the playoff and bowl games, it seems like an appropriate time to recommend a change in behavorial patterns for the contestants and coaches.

Why is it that football players invariably spit when they are standing along the sidelines? Even the coaches and the anonymous folks who carry the clipboards about on the sidelines spit when they know they are on camera.

If the athletes are the idols of the young folks who watch all these games, why do they put this boorish behavior on public display? This spitting phenomenon is not seen in other sports like basketball, tennis, or bowling. Why is it necessary to expectorate all over the astroturf?

Incidentally, the synthetic carpets on which many football games are played are not self-sterilizing or self-replenishing like normal turf. Therefore, the season-long accumulation of spittle must make for a disagreeable bacterial sea which could complicate minor abrasions to the players!

The NFL continues to use its best and brightest on TV messages for the United Way and for other worthy projects which is admirable, but why do these same characters feel compelled to spit along the sidelines? This behavior undoubtedly influences the enormous number of young kids out there who watch these contests but also carries over to the baseball season. Now baseball players, in general, have enough obnoxious habits when they are picked up by the TV camera lenses. Can't they be prevailed upon to refrain from spitting?

All they have to do is put a pinch between their cheek and gum and swallow!

—Raymond A McCormick, MD, Green Bay

Editorial Board comment: *From* CONTEMPORARY HEALTH JOURNAL, *January 1984—"Twenty-two million people use smokeless tobacco in the United States. Sales of snuff and chewing tobacco are increasing at a rate of 11% a year. Government reports indicate that use among teenage males is increasing by leaps and bounds. Tobacco chewing was once considered a dirty, unsociable, spitting habit. The tobacco industry's advertising campaign is now attempting to attach a macho image to what is still a dirty habit and also damages health. Increasing pressure to require added health warnings in cigarette advertising seems to have sparked a campaign to promote the use of smokeless tobacco. Health warnings are not required in snuff and chewing tobacco ads. The ads present chewing and spitting as a healthful, attractive and macho activity (eg, the TV athlete or cowboy)."*

In India 47% to 73% of the population are tobacco users, most of those using chewing tobacco. Forty-eight percent of the cancers in India are found in the mouth. The journal CANCER *commented on a study of female smokers and snuff dippers in the southeastern United States that showed that the risk of developing cancer of the gums or mouth is 4.6 for smokers and 13 to 48 for snuff dippers depending upon how long the user had indulged in the habit. Teenagers are becoming attracted to a habit that carries a risk of cancer of the mouth. Doctor McCormick is to be commended for writing on this subject. The medical and dental professions should join forces in condemning what appears to be an "end run" around the health warnings of smoking.*

Most of the spitting comes from chewing tobacco. Tobacco is addictive, and chewing tobacco is becoming a more serious problem in younger people. Spitting not only is a poor example for the young but also it can be dangerous: A teenager nearly died over the Christmas holidays after a knee-"burn" incurred in a fall on the basketball floor. Severe infection developed attributed to sliding into spittle. Only with extreme emergency intervention was the cause located and controlled.

Baseball players are far more offensive in the expectoration department than our football heroes—both in volume and content.

Smokeless Tobacco
(Advice to teammates)
From Honus Wagner to Harvey Kuenn
and all those shortstops in between,
In the dugout, don't sit
Downwind of their spit
If you choose to stay warm,
dry, and clean.

I am sorry, Doctor

I AM SORRY, Doctor, but I can't come to you anymore. My company just signed up with an HMO plan and my family and I can't come to you and we can't go to the local hospital. We have been coming to you for over 20 years and I am sorry about the situation.

We do have a choice, though. We may go to two clinics that are roughly 175 miles from here, or to another 80 miles away, or to the nearest one which is only 30 miles away. We do not know a single physician in the HMO plan with which our company is now affiliated. We will continue to come to you at our own expense unless hospitalization or something major becomes necessary.

The patient is sorry, the physician is sorry, and it's a sorry situation!

—Victor S Falk, MD, Edgerton

Editorial Board comment: *Freedom of choice? Not according to this! Freedom to seek? No, according to this! No one likes this, even many of those physicians practicing in HMOs. While the above situation may seem unrealistic, it is not. It is happening now, and this is just the beginning; the sorry mess will snowball!* ■

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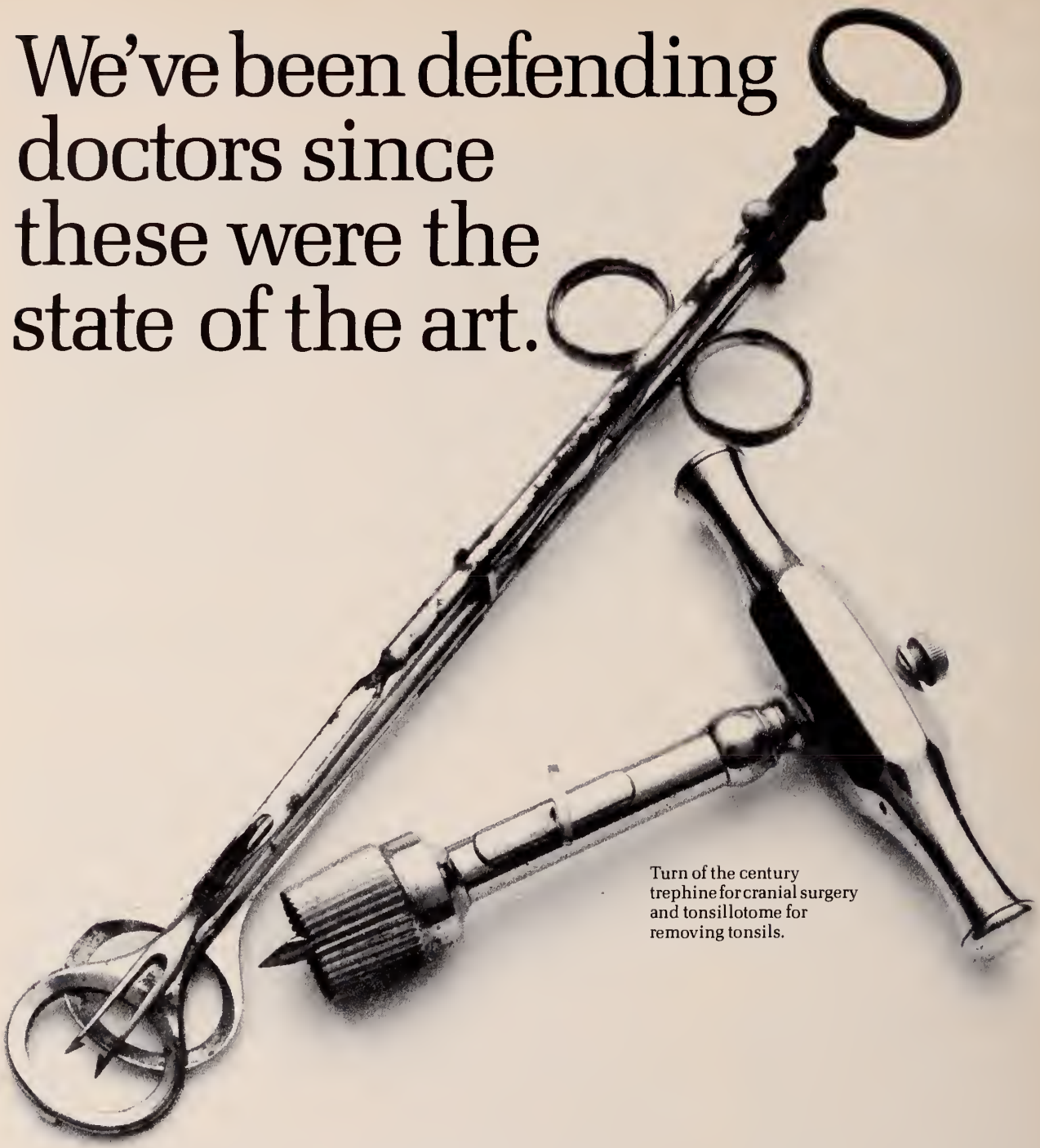

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Diethylstilbestrol (DES) update[1] A message from the DESAD Project

IN RECENT weeks the national media have been reporting the possible adverse effects to offspring of mothers who took the drug, diethylstilbestrol (DES), during pregnancy.

Despite massive nationwide efforts to locate diethylstilbestrol (DES)-exposed females, many such individuals apparently continue to be unaware of the need to be examined and possibly treated for cervical or vaginal complications including certain rare forms of cancer as a consequence of mothers taking DES during pregnancy.

DES was a federally approved drug prescribed from the late 1940s to 1971 primarily for women at risk of miscarriage. Research in the late 1950s began to indicate a small percentage of daughters and sons who suffered adverse consequences from DES, but it was not until 1971 that the FDA issued formal warnings and ordered labeling changes.

Medical alert—DES exposure

The State Medical Society and its Committee on Maternal and Child Health, Michael H Mader, MD, La Crosse, chairman, strongly urge physicians to take the following actions if they have not already done so:

1. **In instances where records are available, notify patients who have been treated with DES during pregnancy so that they can in turn notify their daughters to obtain an examination to determine whether there has been vaginal or cervical tissue change including, in rare cases, the development of certain rare forms of cancer.**

It is recognized that since most of the DES prescribing was done from 20 to 40 years ago, the availability of documentation may be scant or nonexistent. An alternative method is to alert all female patients about DES by providing educational information in person during office visits or making posters or leaflets available in the reception area.

2. **Routinely question every female born between 1940 and 1971 as to her mother's possible exposure to DES. When a DES-exposed daughter is discovered, she should receive a complete gynecologic examination.**

3. **Make similar inquiries of males born between 1940 and 1971. There is evidence that a small percentage of such persons develop reproductive and urinary system abnormalities.**

The State Medical Society also calls upon women and men born in the prime exposure years to take the initiative in talking with their personal physicians and seeking examination if they believe they may have been exposed through their mother's use of DES.

The State Medical Society has received reliable reports that there continue to be numbers of individuals locally and nationwide who have not yet become aware of the possible adverse effects of DES. There also are other reports that are confusing. Therefore, the Society and its Committee on Maternal and Child Health, through its chairman, Michael H Mader, MD, La Crosse, strongly urge physicians to review the following information, which is based solely on the best available data and does not represent personal opinion, and take the appropriate actions if they have not already done so.

DES-EXPOSED DAUGHTERS

Cancer risk. The risk of developing a serious cancer of the vagina remains low. At the present time very few new cases of this tumor are being reported. As exposed women pass the age of 25 years, it appears that their immediate risk of this tumor decreases tremendously. However, it should be noted that in the unexposed women the tumor occurs most frequently in 50 and 60 year-olds. Therefore, all exposed women should have at least annual examinations for life.

It now appears that another type of premalignant tumor is also occurring with greater frequency in exposed women than in the general population. (Robboy, et al, *JAMA*, Dec 7, 1984) This type of neoplasia is called cervical dysplasia or carcinoma in situ. These conditions are changes of the skin of the cervix and vagina which, if left untreated, could eventually become true cancers. Fortunately, the Pap smear is very reliable for detecting the onset of these conditions; and, if they are detected early, may often be treated successfully in the office. This is

another reason why all exposed women should have frequent examinations by a gynecologist who is thoroughly familiar with the evaluation of DES-exposed women. However, some Pap smear laboratories and pathologists are not prepared to diagnose these lesions accurately in exposed women. If a Pap smear or a biopsy is reported to the physician as being abnormal, we suggest that the physician forward the sample to one of the DES centers for further evaluation before any treatment is begun.

Pregnancy. While some studies of selected patients have suggested that DES is related to infertility problems, controlled studies (including DESAD [Diethylstilbestrol Adenosis] Project) have not demonstrated problems in the ability to become pregnant. Although occasional problems have been encountered, this seems to be the exception rather than the rule.

Unfortunately, once pregnancy occurs DES-exposed women are more likely to experience unfavorable outcomes than is the general population. Spontaneous abortion (miscarriage) is the most common problem encountered. However, ectopic (tubal) pregnancy and premature delivery are also complications which occur with some increased frequency. As soon as a DES woman becomes pregnant, she should let her obstetrician know of her exposure. DES-exposed women need much more intensive prenatal care than do unexposed women.

The reasons for these pregnancy problems have not been completely explained. It does appear, however, that the shape of the uterus and cervix may play some important role. Unfortunately, it is not possible to predict the pregnancy outcome based on what is observed at the time of the clinical examination, and x-rays of the uterus (hysterosalpingogram) are not advised for routine screening. Each patient must be watched carefully throughout the pregnancy.

Medical diseases. There are no data at present to suggest that exposed women are more likely to develop any specific medical disease than unexposed women. Some physicians may have questionnaires that ask patients about medical illnesses they may have had. The purpose of these questionnaires is to determine, with some certainty, whether any particular diseases (other than problems with the female organs) are linked to DES exposure. Patients' answers to these questions will be most helpful to physicians.

DES-EXPOSED SONS

In general, the news for DES-exposed sons is good. Although initially there had been some concern about the ability of exposed males to father children, a recent study has shown no difference between exposed and unexposed men. (Leary, et al, *JAMA,* Dec 7, 1981) The exposed men have the same number of children, the same sperm counts, and the same sexual history as unexposed males.

Certain conditions in exposed males must be completely evaluated, however. Although there is no evidence that undescended testes occurs more commonly in exposed males, the patient should seek complete evaluation from a physician if this condition is present.

DES-EXPOSED MOTHERS

DES-exposed mothers (the women who actually took the drug) have recently been reported to have breast cancer more frequently than unexposed women in the general population. (Greenberg, et al, *New England Journal of Medicine,* Nov 6, 1984) Several years ago there had been some suggestion of this, but detailed studies at that time failed to detect a difference between DES mothers and women in the general population. Because breast cancer occurs largely in older women, it was not possible to detect the small difference until the mothers reached a more advanced age. Now, however, it appears that there is a true difference, but the likelihood of any one individual developing the disease is still quite small.

All DES mothers should perform monthly self-breast examination. This technique may be learned through various services in most communities. The American Cancer Society sponsors training programs in many areas of the United States.

Besides self-examination each woman should see a physician at least annually for breast examination. Mammography may be helpful in determining whether a cancer is present. Mammography is useful for only certain types of breast problems, and routine screening in certain age groups has been shown to be of no benefit. Nonetheless, there remains a group of women for which the technique is very beneficial. The DES-exposed mother should ask her doctor about this technique and have the test performed on the schedule that the doctor recommends.

EXAMINATION AND REFERRAL OF DAUGHTERS[2]

The examination of a DES-exposed female is, with some amplification, similar to a routine pelvic examination. The gynecologic examination used in the DESAD Project to examine DES-exposed daughters is outlined in Table 1. Additional techniques found useful in performing the examination are described. When

changes characteristic of the DES-exposed populations are present, the physician may wish to consult a gynecologist familiar with the details of evaluation and followup of DES-exposed individuals.

Inspection of the vulva. Changes in the vulva have not been associated with DES exposure. If the hymen is unusually tight, a topical anesthetic jelly or spray may reduce discomfort during the initial stages of dilation. If the hymen permits the passage of the index finger, the examination may proceed. The patient should be encouraged to use tampons during menstrual periods as this will facilitate the initial and future examinations.

Palpation of the vagina. Palpation is a crucial part of the DES examination and may provide the only evidence of clear cell adenocarcinoma, especially on the rare occasion when it is located beneath the mucosa. The finger used for palpation should be moistened with water rather than lubricant jelly in order not to ruin the cytologic specimens obtained subsequently. The entire length of the vagina including the fornices should be carefully assessed. During palpation vaginal ridges and structural changes of the cervix may be noted. Areas of thickening or induration should arouse suspicion and be sampled by biopsy.

Table 1—*Order of gynecologic portion of examination of women exposed to DES in utero*

Vulvar inspection
Vaginal and cervical palpation (digital)
Vaginal and cervical inspection (speculum)
Cytology (separate slides of vaginal fornices and cervix)
Colposcopy (optional)
Iodine stain of cervix and vagina
Tissue biopsy of atypical findings
Bimanual (recto-vaginal) examination

Speculum examination. After palpation, a speculum of appropriate size is inserted. In virginal females the Pederson virginal speculum is frequently effective when the standard virginal speculum is too short to permit examination of the entire length of the vagina as well as the fornices. Warm water, not jelly, should be used for lubrication during insertion of the speculum. Excess mucus, sometimes present in the DES-exposed woman, should be gently removed with a moist cotton swab. The epithelial surface of the vagina must be carefully inspected. Grossly, adenosis may appear red and granular, while squamous metaplasia may be indistinguishable from normal squamous epithelium. During the course of gross inspection, the speculum should be gently rotated as it is withdrawn in order to assess properly the entire length of the vagina.

Cytology. The secretions and epithelium in the upper third of the vagina should be thoroughly sampled with a wood or plastic spatula, as should the middle or lower third of the vagina if gross epithelial changes are evident there. The spatula should be rotated along the entire circumference of the vaginal fornices. The vaginal material should be promptly transferred to a slide and immediately placed into fixative. A second sample from the cervix should be obtained from the endocervical canal and ectocervix. Aspiration of the external os may be performed as a method for sampling the endocervical canal. This procedure should be followed by a scrape of the ectocervix. When an abnormal smear is reported, a physician may wish to consult a gynecologist experienced in evaluating DES-exposed daughters.

Colposcopy. Colposcopy, if performed, should be done before iodine staining. The chief benefits of colposcopy are that it permits an accurate assessment of the extent of epithelial changes on the cervix and vagina and can be used as an aid to detect those areas most likely to disclose abnormalities on biopsy. Colposcopy has not proved to be essential in the detection of clear cell adenocarcinoma. This is due to the lack of specific vascular changes with the clear cell adenocarcinoma and to the fact that some tumors may be confined to an intramural location in the vagina and cervix.

Iodine staining. Iodine staining of the vagina and cervix confirms the boundaries of epithelial changes observed by colposcopy, or indicates the boundaries when colposcopy has not been done. If colposcopy has been performed, Lugol's solution at half strength is recommended for iodine staining (half strength is 2.5 percent iodine with 5 percent potassium iodide in water). Otherwise Schiller's solution is recommended (1 Gm iodine and 2 Gm potassium iodide in 300 ml water). Because the iodine stains only the normal (highly glycogenated) surface epithelium lining the vagina and cervix, this technique cannot be relied upon for detecting lesions within the wall. To properly assess the tissues after staining, the speculum is rotated as it is withdrawn. After inspection, the speculum should be reinserted for biopsy, if indicated. Insertion may be facilitated by lubrication with jelly to compensate for the dehydrating effect of the iodine.

Indications for biopsy. Biopsy should be performed whenever the vagina or cervix is indurated, granular, contains a palpable nodule or larger mass, has discrete areas that appear to be of a different color or texture than

the surrounding tissue, or discloses highly atypical colposcopic findings. Random sampling of nonstaining areas of the vagina or the cervix is not recommended since these areas rarely disclose neoplastic or preneoplastic lesions. Ferrous subsulfate (Monsel's solution), silver nitrate, or Gelfoam with tampons may occasionally be required to stop bleeding after biopsy.

Bimanual examination. The bimanual examination should include examination of the vagina and rectum and should be performed in a routine manner.

EXAMINATION SCHEDULE

Initial examination of known or suspected DES-exposed females should be performed after menarche or by the age of 14 years if menarche has not occurred. Examination of younger girls is not advised, unless vaginal bleeding, spotting, or abnormal discharge occurs and then it should be considered mandatory. Hospitalization and examination under anesthesia are rarely necessary.

The interval for followup examination is determined on an individual basis. For most patients with nonstaining epithelial or structural changes in the vagina or cervix or for microscopical changes such as adenosis, yearly examinations are adequate. Patients with abnormal Papanicolaou smears should be referred to a physician experienced in the evaluation of DES-exposed women. Before a diagnosis of dysplasia is considered established, all abnormal cytologic specimens should be reviewed by a pathologist who is thoroughly familiar with the changes in samples from DES-exposed women since immature squamous metaplasia is frequently difficult to distinguish from dysplasia.

Important steps at the followup examination include palpation, inspection, and cytology. Attention should be focused on the changes observed since the initial evaluation. Cervical cytology is presently performed each year. If there are no epithelial changes in the vagina, smears from the vagina can be omitted. Women should be asked about interval bleeding or abnormal discharge.

EDUCATION AND COUNSELING

Knowledge of DES exposure without sufficient information and understanding can produce great anxiety. DES-exposed women have anger, guilt, and fear about the risk of cancer and concerns about fertility and their sexual self-image. For this reason, it is important that time be allocated at the initial examination for the mother and her daughter to receive complete and accurate information and assurance.

Explanations must be given which are appropriate to the age of the patient and in terms she can understand. Educational materials, such as written descriptions of the examination or drawings of the changes associated with DES exposure can be given to the patient when she arrives for her appointment, thus allowing her some time to prepare questions.

APPEAL TO MEDIA

The State Medical Society also is appealing to the media and other health-related organizations to continue the campaign to find as many DES-exposed persons as possible and get them to examination. Early discovery of DES exposure and prompt followup with a physician is the key to prevention and treatment.

The State Medical Society also is making available leaflets and posters in an effort to find the last remaining individuals who have not already taken precautionary measures aimed at discovery and treatment of DES-exposed conditions.

REFERENCES

1. DES Update, a message from the DESAD Project, National Cancer Institute.
2. Robboy SJ, Noller KL, Kaufman RH, et al: Prenatal diethylstilbestrol (DES-exposure): Recommendations of the Diethylstilbestrol Adenosis (DESAD) Project for the Identification and Management of Exposed Individuals, Dept of Health, Education, and Welfare, NIH Publication No. 81-2049, March 1981, Government Printing Office.

—Prepared by *Deb Powers,* Policy Analyst, SMS Physicians Alliance Division ■

Physicians who practice, preach

Physicians with better personal health habits and more positive attitudes toward offering advice counsel a broader range of patients and counsel more aggressively, say researchers from The Rand Corporation of Santa Monica, Calif., and from Los Angeles, in the November 23, 1984 *Journal of the American Medical Association.* Kenneth B Wells, MD, MPH, and colleagues say they examined the relation of physicians' clinical specialty, personal health habits and health-related beliefs to their practices in counseling about smoking, weight, exercise and alcohol use. Those with good habits counseled good habits. "Surgeons counsel less than nonsurgeons, even after controlling for differences in health-related attitudes and personal habits," they add. ■

Child abuse and neglect

The law—explanation and implication

ACCORDING TO the specific guidelines set forth in "Current Opinions of the Judicial Council of the American Medical Association—1984" the obligation, both legal and ethical, to report suspected or blatant cases of abuse is clearly defined.

Wisconsin was one of the first states in the nation to enact a statute that required the reporting of suspected child abuse. In a recent issue of *JAMA*, Marilyn Heins, MD stated that

> "[r]eporting is a mechanism to prevent fatal child abuse or future injuries by setting child protective services in motion . . .
>
> The intent of all the reporting laws is to protect the child rather than punish the perpetrators. Therefore, most states mandate immediate investigation of the report and appropriate action to protect the child, ranging from the removal of the child from the home to ongoing social services for the family."[1]

With these goals in mind, the reporting of either a suspected or blatant case of child abuse becomes a necessity in order to protect the child. The physician does not become the accuser, but merely a facilitator for the protection of the child. When reporting the case, if the physician feels comfortable in aiding the treatment and followup, he may wish to offer his services. In a majority of the cases, the Child Protection Services will then work with the physician to insure ongoing treatment and rehabilitation.

But reporting is only a part of the solution to the problem of child abuse. Greater role specificity of the many professionals involved is needed. Professionals also must come to grips with society's conflicts between intervening to protect the child on the one hand and upholding the sanctity of the family and its privacy on the other.

Under the new law relating to reporting of child abuse and neglect (1983 Wisconsin Act 172), the definition of child abuse was expanded to include:

1. Violating s. 940.203, Stats., relating to *sexual exploitation* of children;
2. Permitting or requiring a child to violate s.944.30, Stats., relating to *prostitution;* and
3. Covering "emotional damage," which is defined to mean harm to a child's psychological or intellectual functioning:
   (a) which is exhibited by severe anxiety, depression, withdrawal or a combination of those behaviors;
   (b) which is caused by the child's parent, guardian, legal custodian or other person exercising temporary or permanent control over the child; and
   (c) for which the child's parent, guardian or legal custodian has failed to obtain the treatment necessary to remedy the harm.

[The new law appears in its entirety following this article.]

The Act specifies that "emotional damage" may be demonstrated by a substantial and observable change in behavior, emotional response or cognition that is not within the normal range for the child's age and state of development.

Under prior law, those persons required by statute to report child abuse had to report only if they had "reasonable cause to suspect" that a child, seen in the course of professional duties, had been abused. The Act provides that persons required to report must also report situations in which they have *reason* to believe that a child

Table 1—*Growth of reporting (1979–1982)**

Preliminary	Indicated	Completed	% Increase
1979–8020	7123	1154	15.5
1980–8286	7737	1430	18.5
1981–8500	8230	1482	18.0
1982–9067	8822	1754	19.9

*Source: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

Table 2—*Reporting of abuse only (1980–1982)**

Preliminary	Indicated	% Increase
1980–3650	875	24.0
1981–4149	990	23.9
1982–4606	1154	25.1

*Source: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

[1]Heins M: The 'battered child' revisited. *JAMA* 1984(Jun 22/29);251(24):3297.

seen, in the course of professional duties, has been threatened with injury and that abuse of the child will occur. The inclusion of threatened abuse expands the number of situations in which a report is required.

The issue of responsibility to report cases of known, nonincestual sexual intercourse is, at best, a gray area. According to L Edward Stengel, the President-Elect of the Wisconsin District Attorneys Association, physicians should use their best judgment when assessing these cases. There is no clearcut, definitive answer to this highly controversial issue, and concerned and interested physicians should work toward the possibility of statutory clarification and change.

The penalty for a person who wilfully fails to file a required report ranges from a fine of not more than $100 or imprisonment for not more than six months, or both, to a fine of not more than $1000 or imprisonment for not more than six months, or both.

Table 3—*Reporting of child neglect only (1980–1982)**

PRELIMINARY	INDICATED	% INCREASE
1980-4149	530	12.8
1981-3889	458	11.8
1982-4044	579	14.3

Wisconsin's rate of substantiated cases was 1.29 children per 1000 children. However, according to the US Department of Health & Human Services, only one-third of all abused and neglected children ever comes to the attention of the child protective services system.

*SOURCE: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

"Current Opinions of the Judicial Council of the American Medical Association—1984"

[2.02]

Laws that require the reporting of cases of suspected abuse of children and elderly persons often create a difficult dilemma for the physician. The parties involved, both the suspected offenders and the victims, will often plead with the physician that the matter be kept confidential and not be disclosed or reported for investigation by public authorities.

Children who have been seriously injured, apparently by their parents, may nevertheless try to protect their parents by saying that the injuries were caused by an accident, such as a fall. The reason may stem from the parent-child relationship or fear of further punishment. Even institutionalized elderly patients who have been physically maltreated may be concerned that disclosure of what has occurred might lead to further and more drastic maltreatment by those responsible.

The physician who fails to comply with the laws requiring reporting of suspected cases of abuse to children and elderly persons and others at risk can expect that the victims could receive more severe abuse that may result in permanent bodily or brain injury or even death. (emphasis added)

Public officials concerned with the welfare of children and elderly persons have expressed the opinion that the incidence of physical violence to these persons is rapidly increasing and that a very substantial percentage of such cases is unreported by hospital personnel and physicians. An important element that is sometimes overlooked is that a child or elderly person brought to a physician with a suspicious injury is the patient whose interests require the protection of law in a particular situation, even though the physician may also provide services from time to time to parents or other members of the family.

The obligation to comply with statutory requirements is clearly stated in the Principles of Medical Ethics. As stated at 1.02, the ethical obligation of the physician may exceed the statutory legal requirement. (I,III)

Table 4—*Type of abuse or neglect—completed 1982 reports**

TYPE OF ABUSE OR NEGLECT	TOTAL
Total reports of individual children (not incidents)	8803
Brain damage	2
Skull fracture	28
Subdural hemorrhage or hematoma	12
Bone fracture	87
Dislocation/sprain/twisting/shaking	46
Internal injuries	25
Malnutrition	88
Failure to thrive	59
Exposure to elements	57
Locking in/out	125
Poisoning (unintentional)	6
Burns, scald	217
Cuts, bruises, welts	2621
Sexual abuse	1470
Congenital drug addiction	3
Physical neglect	2644
Medical neglect	372
Abandonment	188
Lack of supervision	2070
Other injury	547

*SOURCE: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

Under prior law, any person or institution participating in good faith in the making of a report, ordering or taking of photographs, or ordering or performing medical examinations of a child under the child abuse and neglect statute is immune from any liability, civil or criminal, that results by reason of the action. The Act expands this immunity provision to include any person or institution conducting an investigation under the child abuse and neglect statute.

Any person who makes a report in good faith is protected in the statute. But there is also the protection of confidentiality. (s.48.981)(7)(a) The source of a report remains confidential, except in the very rare cases when prevention and intervention prove unsuccessful and a court hearing requires the mandated reporter to testify. The report is also subject to criminal defense discovery, if so indicated.

While mandated reporters may remain anonymous, it is recommended that they identify themselves, not only to authorities when making the report but also to the victim (to assure that the physician is there to help).

If a physician fails to report a suspected or blatant case of child abuse, he not only places the child in danger of more serious harm but also the foundation on which a legal case against the offender rests becomes tenuous. Physical evidence is generally unavailable and the case more often than not rests solely on the child's testimony. The physician may believe that he is helping the situation by agreeing to not report and by attempting to treat the victim and offender, but he may in fact diminish the ability to adequately insure that the offender will continue therapy and/or the offense will not happen again.

An Ad Hoc Committee on Child Abuse was recently initiated by the State Medical Society of Wisconsin's Committee on Mental Health and various specialties are represented. Major goals of the Committee are to:

- aid the physician, through educational materials and lecture sessions, in diagnosis, reporting, and followup of cases of child abuse;
- develop a generic protocol for physicians to follow in suspected or blatant cases of abuse occurring in children;

Table 5—*Four most frequently reported incidents of child abuse and/or neglect**

Type of Abuse/Neglect	1979	1980	1981	1982
Physical Neglect	19	34.5	32.6	30.0
Cuts/Welts/Bruises	34	30.0	29.0	29.8
Lack of Supervision	15	22.9	22.4	23.5
Sexual Abuse	27	12.4	14.8	16.9

Please note: The percentage listed above may approach or exceed 100 percent since any one child may be a victim of several different types of abuse or neglect.

*Source: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

Table 7—*Case disposition by result**

	Indicated Abuse	Indicated Neglect	Indicated Abuse & Neglect	Unfounded	Total
Child at home	96	371	6	6535	7819
Disposition pending	23	11	1	24	59
Voluntary placement	63	46	2	119	230
Court-ordered placement	86	99	12	129	326
Consent to adoption	0	2	0	1	3
Child died	2	2	0	5	9
Other	73	48	0	232	353
Unreported	811	0	0	22	23
TOTAL	1154	579	21	7068	8822
%	13.1	6.6	0.2	80.1	

*Source: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

Table 6—*Total reports received by mandated reporters completed 1982 investigations**

Reporter's Occupation	Count	%
Private physician	70	0.8
Hospital-clinic physician	216	2.4
Medical examiner	1	0.0
Nurse	325	3.7
Dentist	8	0.1
Chiropractor	1	0.0
Other hospital clinic	295	3.3
Other medical/mental health	253	2.9
Social or public assistance worker	645	7.3
School teacher	182	2.1
School administrator	914	10.4
Child care worker	65	0.7
Police law enforcement	864	9.8
Other	18	0.2
	3857	44.0
(Healthcare providers	1168	30.3)

*Source: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

- develop a liaison between social service departments, law enforcement, and health-care providers, to better understand, identify, and work with both victim and offender, and aid in rehabilitation; and
- conduct an educational meeting on child abuse. The session could be done as a panel discussion with a question and answer period. Materials and information arising from this meeting would be distributed to interested individuals.

Ad Hoc Committee on Child Abuse members are: Richard Roberts, MD, JD, Darlington (family practitioner/lawyer); Richard Edwards, MD, Richland Center (family practitioner); Pauline Jackson, MD, La Crosse (psychiatry); and Martin Fliegel, MD, Madison (child psychiatry). Specialty representatives are: June Dobbs, MD, Child Development Center, Milwaukee Children's Hospital (pediatrician); and Fred Devett, Madison (psychotherapist).

The March edition of the *WMJ* will address "what happens after the report is made" with services that are provided, legal actions, and outcomes of typical cases.

—Prepared by *Deb Powers,* Policy Analyst, SMS Physicians Alliance Division ■

STATE OF WISCONSIN

Date of enactment: March 22, 1984

1983 Wisconsin Act 172

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 48.207 (3) of the statutes is amended to read:

48.207 (3) A child taken into custody under s. 48.981 may be held in a hospital, foster home, relative's home or other appropriate medical or child welfare facility which is not used primarily for the detention of delinquent children.

SECTION 2. 48.981 (1) (a), (c) and (d) of the statutes are amended to read:

48.981 (1) (a) "Abuse" means any of the following:

1. Physical injury inflicted on a child by other than accidental means.

2. Sexual intercourse or sexual contact under s. 940.225.

(c) "County agency" means a county child welfare agency under s. 48.56 (1) or a community human services board under s. 46.23.

(d) "Neglect" means failure, refusal or inability on the part of a parent, guardian, legal custodian or other person exercising temporary or permanent control over a child, for reasons other than poverty, to provide necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child.

SECTION 3. 48.981 (1) (a) 3 to 5, (cm) and (e) to (h) of the statutes are created to read:

48.981 (1) (a) 3. A violation of s. 940.203.

4. Permitting or requiring a child to violate s. 944.30.

5. Emotional damage.

(cm) "Emotional damage" means harm to a child's psychological or intellectual functioning which is exhibited by severe anxiety, depression, withdrawal or outward aggressive behavior, or a combination of those behaviors, which is caused by the child's parent, guardian, legal custodian or other person exercising temporary or permanent control over the child and for which the child's parent, guardian or legal custodian has failed to obtain the treatment necessary to remedy the harm. "Emotional damage" may be demonstrated by a substantial and observable change in behavior, emotional response

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or cognition that is not within the normal range for the child's age and stage of development.

(e) "Physical injury" includes but is not limited to lacerations, fractured bones, internal injuries, severe or frequent bruising or great bodily harm as defined under s. 939.22 (14).

(f) "Record" means any document relating to the investigation, assessment and disposition of a report under this section.

(g) "Reporter" means a person who reports suspected abuse or neglect or a belief that abuse will occur under this section.

(h) "Subject" means the child who is the victim or alleged victim of abuse or neglect, the child's parent or any other person specified in a report or record who is alleged or determined to have abused or neglected the child.

SECTION 4. 48.981 (2) of the statutes is amended to read:

48.981 (2) PERSONS REQUIRED TO REPORT CASES OF SUSPECTED CHILD ABUSE OR NEGLECT. A physician, coroner, medical examiner, nurse, dentist, chiropractor, optometrist, other medical or mental health professional, social or public assistance worker, school teacher, administrator or counselor, child care worker in a day care center or child caring institution, day care provider, alcohol or other drug abuse counselor, member of the treatment staff employed by or working under contract with a board established under s. 46.23, 51.42 or 51.437, physical therapist, occupational therapist, speech therapist, emergency medical technician—advanced (paramedic), ambulance attendant or police or law enforcement officer having reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected or having reason to believe that a child seen in the course of professional duties has been threatened with an injury and that abuse of the child will occur shall report as provided in sub. (3). Any other person including an attorney having reason to suspect that a child has been abused or neglected or reason to believe that a child has been threatened with an injury and that abuse of the child will occur may make such a report. No person making a report under this subsection may be discharged from employment for so doing.

SECTION 5. 48.981 (3) (title), (a) and (b) 1 and 2 of the statutes are amended to read:

48.981 (3) (title) REPORTS; INVESTIGATION. (a) (title) Referral of report of suspected child abuse or neglect. Persons required to report under sub. (2) shall immediately contact, by telephone or personally, the county agency, sheriff or city police department and, in the case of American Indian children, the tribal government and shall inform the agency or department of the facts and circumstances contributing to a suspicion of child abuse or neglect or to a belief that abuse will occur. The sheriff or police department shall within 12 hours, exclusive of Saturdays, Sundays or legal holidays, refer to the county agency and, in the case of American Indian children, the tribal government all cases reported to it. The county agency may require that a subsequent report be made in writing. Each county agency shall adopt a written policy specifying the kinds of reports it will routinely report to local law enforcement authorities.

(b) 1. Any person reporting under this section may request an immediate investigation by the sheriff or police department if the person has reason to suspect that a child's health or safety is in immediate danger. Upon receiving such a request, the sheriff or police department shall immediately investigate to determine if there is reason to believe that the child's health or safety is in immediate danger and take any necessary action to protect the child.

2. If the investigating officer has reason under s. 48.19 (1) (c) or (d) 5 to take a child into custody, the investigating officer shall take the child into custody and deliver the child to the intake worker under s. 48.20.

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SECTION 6. 48.981 (3) (c) 1 to 5 of the statutes are repealed and recreated to read:

48.981 (3) (c) 1. Within 24 hours after receiving a report under sub. (3) (a), the county agency shall, in accordance with the authority granted it under s. 48.57 (1) (a), initiate a diligent investigation to determine if the child is in need of protection or services. The investigation shall include observation of or an interview with the child, or both, and, if possible, a visit to the child's home or usual living quarters and an interview with the child's parents, guardian or legal custodian. At the initial visit to the child's home or living quarters, the person making the investigation shall identify himself or herself and the county agency involved to the child's parents, guardian or legal custodian. The county agency may contact, observe or interview the child at any location without permission from the child's parent, guardian or legal custodian if necessary to determine if the child is in need of protection or services, except that the person making the investigation may enter a child's home or living quarters only with permission from the child's parent, guardian or legal custodian or after obtaining a court order to do so.

2. If the person making the investigation determines that any child in the home requires immediate protection, he or she shall take the child into custody under s. 48.08 (2) or 48.19 (1) (c) and deliver the child to the intake worker under s. 48.20.

3. If the county agency determines that a child, any member of the child's family or the child's guardian or legal custodian is in need of services, the county agency shall offer to provide appropriate services or to make arrangements for the provision of services. If the child's parent, guardian or legal custodian refuses to accept the services, the county agency may request that a petition be filed under s. 48.13 alleging that the child who is the subject of the report or any other child in the home is in need of protection or services.

4. The county agency shall determine, within 60 days after receipt of a report, whether abuse or neglect has occurred or that the child has been threatened with an injury and that abuse of the child is likely to occur. The determination that abuse or neglect has occurred may not be based solely on the fact that the child's parent, guardian or legal custodian in good faith selects and relies on prayer or other religious means for treatment of disease or for remedial care of the child. In making a determination that emotional damage has occurred, the county agency shall give due regard to the culture of the subjects and shall establish that the person alleged to be responsible for the emotional damage is unwilling to remedy the harm. This subdivision does not prohibit a court from ordering medical services for the child if the child's health requires it.

5. The county agency shall maintain a record of its actions in connection with each report it receives. The record shall include a description of the services provided to any child and to the parents, guardian or legal custodian of the child. The county agency shall update the record every 6 months.

SECTION 7. 48.981 (3) (c) 6 and 9 of the statutes are repealed.

SECTION 8. 48.981 (3) (c) 7 and 8 of the statutes are renumbered 48.981 (3) (c) 6 and 7 and amended to read:

48.981 (3) (c) 6. The county agency shall, within 60 days after it receives a report from a person required under sub. (2) to report, inform the reporter what action, if any, was taken to protect the health and welfare of the child who is the subject of the report.

7. The county agency shall cooperate with law enforcement officials, courts of competent jurisdiction, tribal governments and other human service agencies to prevent, identify and treat child abuse and neglect. The county agency shall coordinate the development and provision of services to abused and neglected children and to families where abuse or neglect has occurred or to children and families where circumstances justify a belief that abuse will occur.

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SECTION 9. 48.981 (3) (c) 8 of the statutes is created to read:

48.981 (3) (c) 8. Using the format prescribed by the department, each county agency shall provide the department with information about each report it receives and about each investigation it conducts. This information shall be used by the department to monitor services provided by county agencies. The department shall use nonidentifying information to maintain statewide statistics on child abuse and neglect, and for planning and policy development.

SECTION 10. 48.981 (3) (d) of the statutes is repealed and recreated to read:

48.981 (3) (d) Independent investigation. If an agent or employee of a county agency required to investigate under this subsection is the subject of a report, or if the county agency determines that, because of the relationship between the county agency and the subject of a report, there is a substantial probability that the county agency would not conduct an unbiased investigation, it shall, after taking any action necessary to protect the child, notify the department. Upon receipt of the notice, the department or an agency designated by it shall conduct an independent investigation. The powers and duties of the department or other agency making an independent investigation are those given to county agencies under sub. (3) (c). In this paragraph, "agent" includes, but is not limited to, a foster parent or other person given custody of the child or a human service professional of a community board established under s. 46.23, 51.42 or 51.437, if the professional is working with the child under contract with or under the supervision of the county agency.

SECTION 10m. 48.981 (4) of the statutes is amended to read:

48.981 (4) IMMUNITY FROM LIABILITY. Any person or institution participating in good faith in the making of a report, conducting an investigation, ordering or taking of photographs or ordering or performing medical examinations of a child under this section shall have immunity from any liability, civil or criminal, that results by reason of the action. For the purpose of any proceeding, civil or criminal, the good faith of any person reporting under this section shall be presumed.

SECTION 11. 48.981 (6) of the statutes is amended to read:

48.981 (6) PENALTY. Whoever wilfully violates this section by failure to report as required, may be fined not more than $1,000 or imprisoned not more than 6 months or both.

SECTION 12. 48.981 (7) to (9) of the statutes are repealed.

SECTION 13. 48.981 (7) (a) 3 to 9 and 11 and (b) to (e) of the statutes are created to read:

48.981 (7) (a) 3. An attending physician for purposes of diagnosis and treatment.

4. A child's foster parent or other person having custody of the child.

5. A professional employe of a community board established under s. 46.23, or 51.42 or 51.437 who is working with the child under contract with or under the supervision of the county agency.

6. A multidisciplinary child abuse and neglect team recognized by the county agency.

7. Another county agency currently investigating a report of suspected child abuse or neglect involving the subject of the record or report.

8. A law enforcement officer or agency for purposes of investigation or prosecution.

9. A court or administrative agency for use in a proceeding relating to the licensing or regulation of a facility regulated under this chapter.

11. The county corporation counsel or district attorney representing the interests of the public in proceedings under subd. 10.

(b) Notwithstanding par. (a), either parent of a child may authorize the disclosure of a record for use in a child custody proceeding under s. 767.24 when the child has been the subject of a report.

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Any information that would identify a reporter shall be deleted before disclosure of a record under this paragraph.

(c) Notwithstanding par. (a), a parent who is the subject of a report may authorize the disclosure of a record to any other person. The authorization shall be in writing. Any information that would identify a reporter shall be deleted before disclosure of a record under this paragraph.

(d) The department may have access to any report or record maintained by a county agency under this section.

(e) A person to whom a report or record is disclosed under this subsection may not further disclose it, except to the persons and for the purposes specified in this section.

SECTION 14. 48.981 (10) (title) of the statutes is renumbered 48.981 (7) (title).

SECTION 15. 48.981 (10) (a) 1. (intro.), a and b of the statutes are renumbered 48.981 (7) (a) (intro.), 1 and 2 and amended to read:

48.981 (7) (a) (intro.) All reports and records made under this section and maintained by the department, county agencies and other persons, officials and institutions shall be confidential. Reports and records may be disclosed only to the following persons:

1. The subject of a report, except that the person or agency maintaining the record or report may not disclose any information that would identify the reporter;.

2. Appropriate staff of the department or a county agency.

SECTION 16. 48.981 (10) (a) 1. c and d of the statutes are renumbered 48.981 (7) (a) 10 and 12 and amended to read:

48.981 (7) (a) 10. A court conducting proceedings related to a petition under s. 48.13 or a court conducting dispositional proceedings under subch. VI in which abuse or neglect of the child who is the subject of the report or record is an issue.

12. A person engaged in bona fide research, with the permission of the department. Information identifying subjects and reporters may not be disclosed to the researcher.

SECTION 17. 48.981 (10) (a) 2 and 3 of the statutes are repealed.

SECTION 18. 48.981 (10) (b) of the statutes is renumbered 48.981 (7) (f) and amended to read:

48.981 (7) (f) Any person who violates this subsection, or who permits or encourages the unauthorized dissemination or use of information contained in reports and records made under this section, may be fined not more than $1,000 or imprisoned not more than 6 months or both.

SECTION 19. 48.981 (11) and (12) of the statutes are renumbered 48.981 (8) and (9), and 48.981 (9), as renumbered, is amended to read:

48.981 (9) ANNUAL REPORTS. No later than October 1 of each year the department shall prepare and transmit to the governor and the legislature a report on the status of child abuse and neglect programs. The report shall include a full statistical analysis of the child abuse and neglect reports made through the last calendar year, an evaluation of services offered under this section and their effectiveness, and recommendations for additional legislative and other action to fulfill the purpose of this section. The department shall provide statistical breakdowns by county, if requested by a county.

SECTION 20. Nonstatutory provision. Six months after the effective date of this act, the department of health and social services shall destroy all identifying records of the central child abuse registry maintained under section 48.981 (8), 1981 stats. ■

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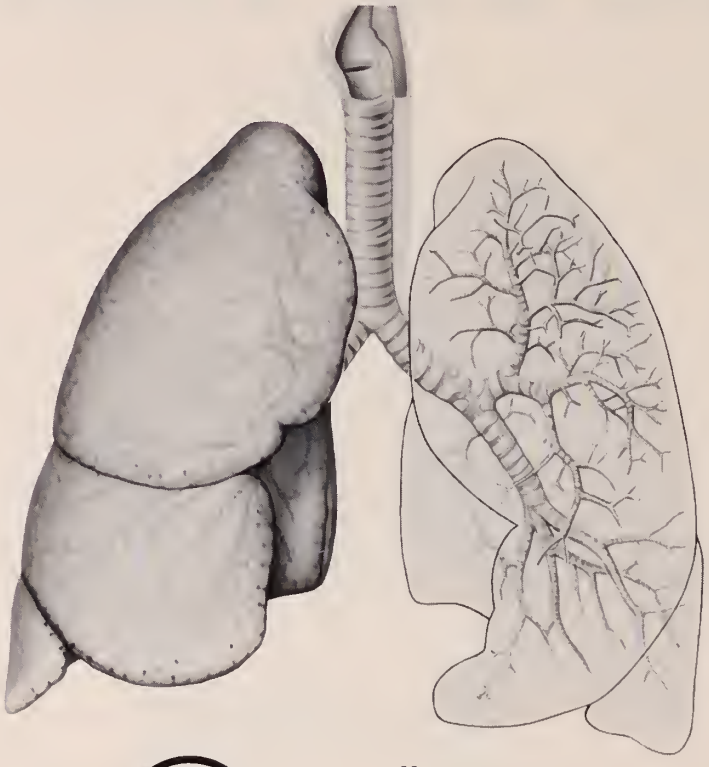

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Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out

Precautions *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

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Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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Ethical decision-making in the care of seriously ill patients

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Abstract. *Our limitation of resources and concerns with the quality of human life have moved the ethical decision process into the center of medical practice. This article reviews and discusses the legal, medical, philosophical, and political aspects of ethical decision-making. It proposes an orderly sequence of clinical assessment, communication with the patient and the family, respect for their beliefs and values, and finally compassionate guidance into the difficult choices. The appropriate documentation of this process and the role of others involved in the care of the patient are outlined. The role of consultants, physician peers, ethics committees, and courts in the resolution of conflict is discussed. Finally, the article stresses the need for a consensus among healthcare providers and the public which is generous and flexible and not restrictive and impractical when cast into law.*

Key Words: Ethical decision-making, Critical care, Medical ethics

EUTHANASIA has once again become a burning issue. Our press is still reverberating with comments and reactions of public officials concerning the extent and cost of the care our elderly and seriously ill receive in their last years of life.[1] Once again we have entered into the debate as to where the wisdom is to control the new technology which our scientists and technicians have developed for us, a comprehensive technology of hospitals, of human skills, of machines and of procedures. Before I summarize and explain our new insights, let me by contrast recall the tragic abuse of euthanasia which 45 years ago occurred in a highly civilized society.

In 1933 Hitler's government in Germany passed the "Law for the Preservation of Offspring with Hereditary Illnesses" which mandated sterilization of certain afflicted individuals. In 1935 Hitler contemplated the institution of active euthanasia to eliminate "life unworthy of living" but delayed it because of opposition from the church.[2] In 1939 he issued an order authorizing a small group of designated physicians to grant mercy killing "to certain diseased who are incurable by all human standards and can be declared so on the basis of a most critical evaluation."[2] Approximately 100,000 patients with intractable schizophrenia, severe dementia, and criminal insanity were thus eliminated. Public protest by physicians, lawyers, and courts became progressively louder and the program had to be halted in 1941.

These killings were not sanctioned by German laws which clearly stated that in 1944 "the right to perform euthanasia on patients suffering from conditions with lethal outcome cannot be granted to physicians or any other persons, even when the patient desires relief from suffering."[2] The physicians responsible for these mercy killings were sentenced to death by the Nuremberg War Crimes Tribunal.

These trials also brought out that the mass extermination of Jews and other aliens started on German soil with the same medical selection process of "life unworthy of living" among the concentration camp inmates. This tragedy—among the most horrendous of all times—thus began with medical science and its practitioners being pressed into the service of a totalitarian ideology.[3]

Active euthanasia has been a crime since the principles of medical ethics were first formulated. Physicians and the public should be reminded of another old admonition: "Thou shalt not kill but needst not strive officiously to keep alive." Therein lies the essence of what we nowadays refer to as "passive euthanasia." Can we accept this?

An 83-year-old woman in Phoenix, Arizona, recently requested to be taken off the respirator and be permitted to die. Yet her physicians and hospital officials were afraid to comply with her living will and sought a court order for the protection of their own actions.[4] Two physicians in California were recently submitted to agonizing legal prosecution because they had complied with a family's wishes to remove feeding tubes from a hopelessly brain-damaged patient. Courts in New Jersey are still struggling to decide whether a nephew and legal guardian of a severely demented but not comatose elderly patient were justified in requesting the withholding of all feeding.[5]

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In discussing what an appropriate public framework for ethical decision-making should be, Abram[6] remarked on the episodic and fragmented nature of ad hoc reactions by courts and legislatures when conflict arises over medical-ethical issues. He decries the lack of a comprehensive, orderly approach based on concensus and fears that coercion by government may take over if voluntary concensus does not succeed. Sharing these concerns I wish to summarize here those principles and practices of ethical decision-making which seem to have achieved widespread acceptance and to point out where controversy still exists, and where collaborative deliberation and action by physicians and other representative professionals may achieve a new state of order.

Clinical decision-making is a process which emanates from the physician's mind and takes place within the context of his medical knowledge and wisdom. The context of ethical decision-making, however, entails values and principles which may lie outside of medicine proper and emanate from the society and culture to which both patient and physician belong. The linguistic roots of the word "ethics" lie in "customs," customs which are socially important in the mutual relationships between man and man and between man and his community. It is, therefore, understandable that ethical decision-making in medicine has aroused public interest and has mandated public participation. Death takes place increasingly in public institutions rather than at home as reflected in the following statistics.[7]

The incidence of dying in public institutions in the USA

1949	1958	1977	1983
50%	61%	70%	80%

The sophisticated, new technology of patient care has been applied particularly in the care of the critically ill and has often resulted in the prolongation of dying rather than the extension of useful life. This has been coupled in the last two decades with rising costs of healthcare. Lately it has brought more sharply into focus the limitation of our economic resources and other social priorities with which healthcare expenditures compete.

An ever-increasing share of state and federal tax revenues goes into the terminal care of the elderly and others who are hopelessly ill. Cognizant of these widespread concerns, the federal government has asserted its role in the area of medical ethics in a twofold manner: first by the creation of Institutional Review Boards to which it delegated the task of monitoring the use of human subjects in experimentation and assuring the compliance with ethical standards which were updated in 1979;[8] secondly, in the broader domain of patient care and its ethical basis, by assuming a directive capacity in establishing the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. This commission published standards and guidelines of ethical principles and practice which unquestionably will have binding effects.[7]

Much can be said against the government's meddling into the ethics of medical practice. Medical-ethical decisions are essentially private, transpire between the physicians, the patients and their families, are based on cultural-spiritual values, and should not be overshadowed by political doctrine. Government involvement may lead to the inappropriate centralization of power, the establishment of a rigid bureaucracy, and the infiltration of medical practice by a political morality.[6] On the other side, medicine has been amiss in self-regulation, in establishing appropriate standards for ethical decision-making and, more generally, in addressing the public issues of healthcare. These are: equitable distribution of, and access to, healthcare, and the progressive limitation of financial resources.

Economics and ethics of healthcare intersect at the critical point where valuable resources needed for other programs are spent on the needless extension of the dying process in terminally ill patients. The definition and delineation of the term "quality of life" transcends clinical medicine. It encompasses moral judgment and public values. It is central to all deliberations on medical ethics and has to be derived from public consensus. Therefore, it appears reasonable for the federal government to assume a surrogate function for the public and catalyze this process which ranges from the collection of information to the molding of values and judgment. Here, as in other spheres of its involvement, government will become dangerous only when it disengages from public input and control and imposes coercion which is not supported by consensus.

The law has interposed itself in ethical issues related to the care of patients in various ways. As mentioned above, criminal prosecution of two California physicians on charges of homicide recently ended with their acquittal. They had removed hydration and feeding from a patient who was in an irreversible coma due to anoxic brain damage. Fear of similar prosecution in the state of New York, where there is no brain-death law, resulted in the prolonged respirator support of a patient who was brain-dead from intracranial hemorrhage despite the family's request that all life support be stopped.[4]

Apparently charges of ethical

malpractice have been brought against physicians resulting in civil litigation, but to my knowledge only one physician was found negligent in this respect. The case involved the discontinuation of life support from a brain-dead patient against the wishes of the family[9] and is still under appeal. Ironically litigation against physicians could also result from the maintenance of life support against the wishes of the family, particularly for the recovery of the cost of care and on the charge of assault and battery.[10]

Uncertainty about the law, about the appropriate process of decision-making, and conflict between the wishes of the patient and family on the one side, physicians and hospitals on the other, have resulted in court trials and decisions. Among these are: the Quinlan, Saikevicz, Brother Fox and Storar cases, the verdicts of which have helped to establish clarification and precedent, but also confusion and protest, as in the Saikevicz case.[11]

State legislatures also have addressed ethical issues and passed statutes which recognize brain death as legal death, establish the patient's right to a natural death and the validity of a living will, and delineate the powers of attorney of a surrogate. Wisconsin's Natural Death Act* will be discussed below. In some states Hospital Ethics or Prognosis Committees are recommended or mandated either as part of other legislation or incidental to court decisions as in the Quinlan case.

In general, government feels obligated to assure the protection of human life, while at the same time guaranteeing to the patient the constitutional right to privacy and ensuant right to decide over one's own health and life. It also has to protect the individual from suicidal self-destruction and protect the right of innocent third parties such as children and other dependents. Civil law, on the other side, observes the abidance by normative standards of medical and ethical practice and may prosecute where these appear to be violated.

The ethical decision process involving congenitally deformed as well as defective infants received renewed attention with the recent Baby Doe case. The government's intrusion in these cases appears to be premised on the patient's incompetence and lack of self-determination, the absence of a "substitute judgment" approach in contrast with adults as well as the reliance on arguments of "best interest" and "quality of life." As heartbreaking and agonizing as the decision-making may be in these cases, they are few in numbers compared to the growing proportion of the elderly in our population, every one of whom may eventually have to decide what type of care, and how much, to demand before death.

Ethical decision-making in pediatrics appears to have matured into a visible system based on established standards and experience. Ethics committees and formal consultation emerged here much earlier than in adult care. Courts and judges also have acquired a firm position in the ethical decisions process for the care of infants and children whose parents may be in conflict with physicians and hospitals over religious issues, as for instance in the case of Jehovah's Witnesses and other fundamentalist groups.[12,13]

On April 18, 1984, Governor Earl signed into law Wisconsin's Natural Death Statute, to take effect on October 1, 1984.[14] It allows a competent patient to forego life-supportive measures and devices in case of terminal illness and protects physicians and other providers from legal prosecution. In addition to Wisconsin, 15 other states have similar laws: Alabama, Arkansas, California, Delaware, District of Columbia, Idaho, Kansas, Nevada, New Mexico, North Carolina, Oregon, Texas, Vermont, Virginia, and Washington. Most of these statutes, except those of Arkansas, North Carolina and Virginia, require that the patient be in a terminal condition with death to occur regardless of the application of special life-support measures such as respirators, vasopressor therapy, blood transfusion, and dialysis.

In most of the statutes, including Wisconsin's, the patient's terminal condition must be certified by consultants. In addition, in Wisconsin the patient's death should be imminent within 30 days. Also, under these statutes competent patients may establish such a "living will" anytime in their lives, but there is no provision for the role of legal guardians or surrogates to act on behalf of incompetent patients.

Under the Arkansas and North Carolina statutes the patient has the right to refuse extraordinary treatment which is "calculated to prolong his life" (Arkansas) provided "his condition is determined to be terminal and incurable" (North Carolina). These two statutes significantly digress from the others in that the patients covered by them have the right to refuse treatment which violates their concepts of quality of life. These two statutes thus authorize passive euthanasia while under the others it is assumed that the removal or withholding of life support will not alter the patient's inexorable progression to death.

Wisconsin's Natural Death Statute would be applicable to patients with the following representative conditions: A terminal leukemia patient who is close to death but experiences a complica-

*1983 Wisconsin Act 202, Ch 154. Published in toto in the June 1984 BLUE BOOK issue of the *Wisconsin Medical Journal.*

tion such as respiratory failure or bleeding. In how many of these patients do we not already withhold treatment after appropriate consultation with the family in order not to prolong suffering and in order to conserve valuable resources such as blood? And in how many patients with terminal cardiogenic shock have we already decided not to use cardiopulmonary resuscitation in case of asystole or electromechanical dissociation because it would be like "whipping a dying horse?"

Just as in medicine, authoritative groups assemble research and clinical experience into comprehensive standards of medical care and publicize them by presentation and publication, standards of ethical practice have similarly evolved.[15,7] The following outlines the responsibilities of physicians and institutional providers in ethical decision-making.

An orderly decision process recognizes and attempts to procure the patient's wishes and opinions. It recognizes his constitutional right to refuse treatment and to accept death where by common sense and clinical experience this appears to be appropriate. If patients are incompetent and cannot make a decision or render an opinion, surrogates should be appointed and to the best of their ability decide for the patient. Incompetent patients, such as those with Alzheimer's disease, may still be able to understand the need for a surgical procedure and be able to consent to it. Thus, they should be informed even though the consent form may still require the signature of their legal guardians.[10]

Surrogate decision-making may be based on "substitute judgment" which is the extrapolation of the patient's previous known attitudes and positions as expressed in a "living will" or otherwise into the current clinical situation. If any previous statements are nonexistent or unavailable as in the case of newborn infants, the principle of "best interest" should prevail. What would be in the best interest of the patient's representative situation, to be treated or not, to live or to die?

Another important consideration is that of "quality of life." Human existence is characterized by awareness, the ability to establish and maintain simple communication and relationships, by life-sustaining drives and reflexes such as hunger, thirst, adequate ventilation and airway clearance, by a minimum of intelligence, and by superimposed personal values which may be highly specific and escape normative standards.[16] Will the patient, with or without treatment, continue to exist within such a state? The physician's clinical assessment of the patient's condition has to be in order. This means the patient's current condition and future prognosis have to be identified as closely as possible, if necessary with the help of appropriate consultants. Alternative therapeutic approaches, if available, have to be presented to patient and his family, and their risks and benefits should be discussed.

This does not mean that patient and family are presented with a menu of clinical options from which they are expected to make an agonizing choice. The physician is still in the best position to weigh all factors and circumstances and to formulate a personal recommendation, better than courts, ethics committees or even grieving and confused family members.[17] However, the patient's and family's acceptance of this recommendation should be one of full understanding and, as much as possible, free of guilt and shame. The presence of witnesses, particularly nurses involved in the care of the patient, is highly recommended during the conversation with the patient and family. It will increase their involvement, reduce their sense of guilt when difficult steps will have to be taken such as the removal of life support, and assure the stability of the entire decision process. All conversations and decisions should be documented in the patient's chart, but consenting signatures are not required by the patient, family members or other surrogates, or any witnesses.[7]

Breaking bad news to the family in itself represents clinical artistry. It is best to use a stepwise approach in which, along with the information about the patient's condition, gradual insight into, and understanding of, the disease process is fostered. In the course of a few days the family itself may propose to the physician what he or she intended to recommend from the start. A conclusion which results from the family's own reasoning process is usually accepted best. In order to achieve it the physician should guide rather than preempt the family members' knowledge and thinking.

The way in which a family accepts the bad news of impending death, a hopeless, terminal illness or serious, probably permanent, brain damage is similar to the confrontation of a patient with impending death. The initial disbelief and shock is in proportion to the unexpectedness of the illness or accident. In place of the anger displayed by a dying patient the family tends to show overt or quiet dispair in anticipation of the patient's loss. This may alternate with or be displaced by realistic or unrealistic hopes. Final acceptance and the ability to return to a realistic discussion usually requires another 24-48 hours. At this point some clinical and ethical decisions may have to be made related to life support, organ donation, or transfer to lower levels of

care. Ethical decision-making is another psychological stress test which may uncover anxiety and guilt in the family members, but on the other side the physician may find them surprisingly well-informed and prepared to tackle the sensitive issues. I found the latter to be the case particularly among well-educated people and those whose lives include strong religious commitments.

It is my impression that the decision to limit or terminate life support in hopelessly ill patients is also aided by the sensitivity and courage of the physicians who are responsible for the care of the patient, whether they are specialists or responsible for the patient's primary care. Most importantly, the physician has to transcend the immediate problems of the patient's organ failure, obtain an overview of short- and long-range prognosis and integrate it with the patients' and families' views of life, its values and qualities. It is also helpful for the physicians to have known the patients and their families for some time. A recent study of costs and outcomes on the faculty and community service of a university hospital lends some support to this.[18]

If a conflict exists such as dissent between the physician, patient, and family that cannot be overcome by the involvement of a consultant, the next level of referral should be a hospital ethics committee or other appropriate body. Beyond the ethics committee, recourse to a court will have to be taken unless authoritative figures in the medical community such as a chief-of-staff or department head could effectively arbitrate and enable the family or physicians to accept the proposed change in a care plan.

Statistics which are helpful in estimating survival and neurologic recovery are now available for patients in traumatic and non-traumatic coma, particularly coma ensuing a cardiac arrest.[19,20] Persistent coma after three days accompanied by evidence of brain-stem injury is associated with a less than 5% chance of neurologic recovery to functioning state. Patients with coma due to head injury or metabolic encephalopathy may fare better because of less involvement in the brain stem and mid-brain areas. The limitation or termination of life support can be entertained in patients with coma who were observed for at least three days and whose poor prognosis is supported by the level of neurologic damage and the course of coma.[21] Since these patients are unaware of pain, hunger and thirst, even food and water may be withheld provided physicians and family members concur in this decision.[22]

Another dilemma is presented by the patient in respiratory failure who requires continuous mechanical ventilation. If alert and competent, this patient may request removal from the respirator regardless of outcome. Physicians and nursing staff can concur in this request if all reversible courses such as bronchopneumonia, excessive secretions, and nutritional depletion are optimally controlled. Even then the weaning process should be gradual enough to allow for the recovery of respiratory muscle function and the necessary adjustment of acid-base balance. A more rapid weaning approach towards almost certain death was recently described by Grenvik and includes the judicious use of morphine to control the distress of dyspnea.[23]

Multisystem failure in a patient who is diffusely anasarcous, profoundly hypoalbuminemic and without hope of rapid nutritional resuscitation is another situation with almost certain lethal outcome. Since associated cerebral edema leaves these patients obtunded and unaware of most distress, the merciful withdrawal of the respirator, intravenous fluids, and life-supporting medications appears appropriate and can be discussed with the family.

The Wisconsin Natural Death Act requires that two physicians certify the patient's terminal state and that death is likely within 30 days. This attempt at prognostication can be highly inaccurate.[24]

Nevertheless, some data have become available to support prognosis in critical illness. Outcome in shock is related to the level of the blood lactate,[25] the degree of mixed venous hypoxemia[26] and the presence or absence of an associated acute respiratory distress syndrome.[27] It also can be predicted with close accuracy by the computerized integration of multiple monitoring variables.[28,29]

In renal failure mortality is increased by old age, coexisting cardiac or respiratory failure, diffuse tissue injury due to trauma or sepsis, and malnutrition.[30,31,32,33]

Intermittent hemodialysis for chronic renal dialysis does not affect the quality of life as much as the dependence on a ventilator in severe chronic respiratory failure. Therefore, the decision to institute assisted ventilation represents a real, ethical dilemma.[34] Adult respiratory insufficiency of the non-obstructive type covers a spectrum which ranges from irreversible tissue destruction and high mortality to reversible, transudative edema and a good outcome.[35,36,37] Ventilatory failure associated with chronic obstructive airway disease (COAD) is usually due to superimposed bronchopneumonia or the inspissation of secretions, both potentially reversible. Both types of respiratory failure usually require immediate intubation and ventilatory assistance, yet many of the COAD patients will be able to be weaned off the ventilator after a few days and have a 60%-70% one-year sur-

vival rate. On the other side, more insiduously developing ventilatory failure in COAD, at first amenable to conservative therapy and then followed by progressive decompensation, reflects a higher ratio of irreversible to reversible disease, is associated with a higher mortality and the risk of permanent respirator dependency. Second and third recurrences of ventilatory failure carry a mortality rate of 17%-44% per episode, and a two-year mortality rate of 66%-70%.[38,39] Therefore, the following is a reasonable guideline for the patient with chronic obstructive airway disease:

1. Institute immediate ventilatory assistance if the patient is in acute ventilatory failure unless the patient or his family have made a valid declaration to the contrary.
2. If conservative therapy appears feasible, it should be instituted first. If it fails, assisted ventilation and its risks of creating permanent or long-term ventilator dependence should be discussed with the patient-family. It is reasonable for the patient to reject assisted ventilation particularly if it had been used before. Previous tracheal intubations or tracheostomy also increase the risk of progressive tracheal or subglottic stenosis.

A Massachusetts court decision in the case of Dinnerstein affirmed the right of family members to decide against resuscitation in the case of an incompetent, severely demented patient.[40] When deliberating such limitations of care, one should specify, however, whether cardiopulmonary resuscitation itself is meant or other resuscitative measures such as the use of a respirator or vasopressor drugs with invasive monitoring.

In the context of cardiopulmonary resuscitation (CPR) a case can be made for the distinction of clinical *vs* ethical decision-making.[41] On clinical grounds one may advise against CPR when a patient is already in cardiogenic shock, when a patient with severe chronic obstructive pulmonary disease could not tolerate the risk of fractured ribs or a flail chest, or when existing brain damage entails the risk of further aggravation by any reduction of cerebral blood flow albeit temporary. Here a physician may recommend against these measures out of clinical benefit *vs* risk considerations similar to a surgeon refusing to operate on a high-risk patient. If clinical reasons against CPR are insufficient, ethical arguments move into the foreground and should be handled through the same process of ethical decision-making outlined above.

In many of the categories exemplified above the patient is usually competent and functioning until overcome by a catastrophic illness which requires extraordinary means of life support. This contrasts with another type of patient who is no longer competent because of an irreversible disease process of the brain and who has been permanently reduced to a less-than-human level of function and existence.

Deliberations in courts, by the President's Commission, by experts in medical ethics, and by prominent clinicians have achieved some consensus on the ethical justification of limiting life support in these classes of patients.[7,15] Since the irreversibly comatose patient is unaware of any distress and no longer represents genuine human existence, complex life support such as respirators, life-saving surgery, and blood transfusions may be withheld, as well as simple life support represented by food and water. However, depriving the patient of basic body hygiene such as skin cleansing, care of evacuation, and care of decubitus ulcers may be offensive to family members and the personnel responsible for the patient's care, and this basic care, therefore, should be sustained.

The demented but awake patient also could be deprived of all resuscitative measure but should still be afforded food, water, and other means of comfort and basic care. Whether to use antibiotics or blood transfusions in such patients is controversial but could be resolved by a more thoughtful decision process which looks at quality of life, prognosis, and level

Table 1[15,42,43]—*Summary of current consensus concerning the care of comatose and demented patients*

Life Support	For Whom?	
	Irreversible comatose	*Awake demented*
Complex: Respirators, invasive monitoring, vasopressor therapy, dialysis, transplantation	no	no > maybe
Surgery or other invasive procedures	no	no > maybe
Noninvasive complex therapy (tumor chemotherapy)	no	no > yes
Simple therapy (antibiotics for infections)	no > maybe	no > yes
Simple life support (food, water)	no > yes	yes
Basic body hygiene	yes	yes

of distress. Patients with incurable malignancy, dementia, loss of basic biological drives such as eating or coughing are less likely to be treated than patients who are more intact and have a better prognostic outlook.[42]

Table 1 summarizes the current consensus concerning the care of these types of patients.

The issue of administering food and water to comatose, demented or competent and chronically ill patients is still controversial. The recent decision of a California appellate court in Barber *vs* Superior clearly absolved two physicians of any wrongdoing when they obeyed the family's wishes and withheld food and water from a permanently comatose patient. This is also supported by the President's Commission.[43]

Recently a New York court upheld the right of an 85-year-old competent patient to refuse nourishment because of his despondency over ill health.[44] This contrasts with the 1983 decision of a California court in which a 26-year-old patient with nonterminal cerebral palsy was denied the right to assistance by institutional personnel in her effort to end her life by starvation. In this latter case it may have been the patient's youth or her nonterminal illness which may have persuaded the court to decide in favor of society's obligation to preserve life rather than the patient's right to the privacy of a quiet death.

Under Wisconsin's Natural Death Act food and water are excluded from the means of life support which may be withheld or withdrawn from a terminally ill patient who has made a valid living will. This provision is a variance with all other natural death laws which exclude only medication or medical procedures necessary to provide comfort care or to alleviate pain. Can one, therefore, withhold food or water from a patient in Wisconsin? Probably so, if the patient and family desire it, if the patient has a hopeless or terminal disease in which by all reasonable standards death is preferable to continued misery, and if the patient's or the surrogate's wishes are in accordance with the constitutional right to privacy. However, this decision would not be sheltered by legal immunity.

Even though the Wisconsin Natural Death Act includes the statement that it "does not impair or supersede any person's legal right or responsibility to withhold or withdraw life-sustaining procedures," it also implies that physicians and other providers who comply with requests for withdrawal or withholding of life support under circumstances other than those specified in the act could be held criminally or civilly liable for their actions. It appears that the Wisconsin Natural Death Act is unsatisfactory in many aspects: (1) it covers too small a number of clinical situations for which clinical practice has already established adequate standards, (2) it does not address the majority of cases in which life support does postpone death albeit at the cost of significant suffering and compromised quality of life, and (3) by providing legal immunity to physicians in a greatly restricted number of clinical situations, it may by contrast increase their vulnerability to legal and civil prosecution in the other situations. This could make physicians more reluctant to discontinue or withhold life support in cases which fall outside of the statute with the ironic result that for these patients the psychological and financial costs of their care will increase.

The State of California recently passed a durable power of attorney for healthcare statute under which competent persons may designate a family member or entrusted friend to make relevant decisions concerning their care should they become incapacitated.[45] This decision-making by proxy may rest on the principle of "substitute judgment" or "best interest" and addresses itself particularly to the issues of life support, its institution, limitation, or withdrawal. This new law does not impose as many clinical limitations and restrictions as the natural death acts do and seems to allow for more interpretative decisions by the physicians themselves. It arose out of the dissatisfaction with California's natural death act and seems to point the way for us in Wisconsin as we are also confronted with the shortcoming of our own recently enacted statute.

In the meantime, much of our ethical decision-making will have to continue to be guided by our compassion for the patients and their families as well as good clinical judgment. Our own legal safety will have to rest on the consensus arrived at between physicians, patients, and family members as well as all others directly involved in the care of the patients in question. In addition, we have to ascertain that an appropriate process of decision-making is followed with due recognition of current standards of our medical community. This would also require that more consensus is achieved among clinicians as to how far one should go and how long one should treat patients with the more common conditions such as irreversible debilitation, the terminal cancer patient who may not yet die within the next 30 days, or the patient with severe cardiopulmonary disability. Since we are obligated to have the patients and their families concur in our recommendations, we have some assurance that this consensus of a group of clinicians is not mistaken for a conspiracy.

The extensive list of references is available upon request to the author.

Malignant mesothelioma

Warren H De Kraay, MD, Kenosha, Wisconsin

ABSTRACT. *The recent publicity regarding asbestos exposure in public buildings, asbestos liability suits, and increasing incidents of mesothelioma prompted a study of mesothelioma in Southeast Wisconsin. During the past few years, an increase in the reported cases of mesothelioma has been noted in Racine and Kenosha counties. Certain clinical and radiological findings of mesothelioma are emphasized in this report to enable the physician to make an early diagnosis so prompt treatment can be instituted.*

KEY WORDS. Mesothelioma, Asbestos body, Pleural plaques

DURING the past few years there has been a significant increase in mesothelioma cases in this area and nationally.[1] Since mesothelioma is rare and difficult to diagnose, physicians should be alert regarding the diagnosis and treatment of this disease. Asbestos and mesotheliomas have been correlated since 1960 when a South African physician, JC Wagner, MD, discovered an increasing number of mesothelioma cases in workers in a nearby asbestos mine.[2] The medical profession has taken note of this problem; and since 1964, intensive investigation regarding the relationship between asbestos and mesothelioma and followup of asbestos workers has been accomplished.

Reprint requests to: Warren H De Kraay, MD, 3618 Eighth Ave, Suite 5, Kenosha, Wis 53140 (phone: 414/552-7211). Copyright 1985 by the State Medical Society of Wisconsin.

In the years 1970 to 1980 there were five cases of mesothelioma diagnosed in the Racine and Kenosha areas. Between the years 1981 and 1982 seven cases of mesothelioma were diagnosed in the same two counties. During the years of 1940 to 1980, 27 million people working in 11 US occupations were exposed to asbestos. Eighteen thousand workers in the International Association of Heat and Frost Insulation and Asbestos Workers Union have been followed periodically regarding the development of mesothelioma,[3] and it is estimated that 7% of all asbestos workers will eventually develop mesothelioma between 20 to 40 years after their exposure. Since there is a long interval between exposure to asbestos and cancer, a gradual increase in related deaths will occur until 1990.

It is estimated that between 8000 and 9000 deaths, directly related to asbestos, will occur yearly for the next 20 years. In nearly 80% of malignant mesothelioma cases, a history of an exposure to asbestos can be obtained. However, the duration of exposure to asbestos is difficult to correlate with the onset of mesothelioma. Although a definite threshold has not been established, it appears that the workers in the mines or in an area where there is heavy exposure seem to develop the disease more readily than a bystander-type of exposure. However, family members whose only exposure had been to asbestos contaminated clothes have also developed the disease.

Asbestos fibers are highly carcinogenic with mesothelioma of either the pleural or peritoneal cavity readily induced with experimental instillation of the fibers.[4] Involvement of the peritoneal surface is considered to be either secondary to direct extension from the pleural surface through the diaphragm or secondary to swallowing fibers after the respiratory cilia has moved the fibers from the respiratory tract into the oral cavity.

BENIGN ASBESTOS DISEASE. Asbestos fibers can result in benign variants of the asbestos related disease, such as:

1. Pleural plaques.
2. Calcification of pleural plaques.
3. Pleural effusion.

Asbestos fibers are found in a large percentage of patients with pleural plaques, and pleural plaques may be considered to be diagnostic of asbestos exposure. Pleural plaques usually occur on the diaphragm or posterior lateral chest wall and the visceral pleura is not involved. Asbestos fibers and asbestos bodies are often embedded in the dense fibrous tissue. When the asbestos fiber is located in the respiratory tract, a protein coating results and an "asbestos body" is formed. This is a yellow-brown pigmented, beaded linear structure, which also can be found in association with other silicates. Pleural calcification is usually considered as a later manifestation of pleural plaques. Pleural effusion can occur with benign disease, but it is usually associated with malignant mesothelioma. Ninety percent of patients with malignant mesothelioma develop pleural effusion. There is no conclusive evidence of pleural plaques progressing to malignant mesothelioma; but

since pleural plaques denote exposure to asbestos, these patients should be followed as prospective candidates for the development of malignant mesothelioma.

CASE 1. A 67-year-old white male consulted his family physician because of dyspnea and weakness. He had worked in an asbestos plant for four years, 25 years previously. Physical examination revealed a slender white male with moderate dyspnea. A chest x-ray film revealed a right pneumothorax. A chest tube was inserted with gradual reexpansion of the lung. The chest tube was removed after five days and full lung expansion was noted.

One week later recurrent right pneumothorax was detected, and reinsertion of the chest tube was performed. An air leak persisted for seven days, and a thoracotomy was performed.

At thoracotomy calcified plaques were present over the diaphragm and the lateral chest wall. A pleural bleb was excised and the lung oversewn. Pleurodesis was performed. The excised tissue was examined at three medical centers, and a diagnosis of malignant mesothelioma was made. The patient underwent thoracotomy at another clinic and no obvious malignancy was found. Partial pleurectomy was done and a 4-mm section of the pleura was diagnosed as malignant mesothelioma. The patient has done well postoperatively.

Obviously this represented an unusual situation in which the diagnosis was strictly accidental and the clinical diagnosis unsuspected.

CASE 2. A 62-year-old white female noted dyspnea and chest pain on the right side for two weeks prior to hospitalization. A chest x-ray film revealed right pleural effusion but no definite masses. She had no known exposure to asbestos.

A physical examination revealed minimal dyspnea and decreased breath sounds in the chest on the right side. Thoracentesis yielded bloody fluid, and malignant cells were found. Pleural biopsy revealed malignant mesothelioma.

Since there was no gross chest nodularity on the left side and the right lung was clear, a Stage I mesothelioma was diagnosed. A pleuropneumonectomy was performed with partial diaphragm excision. No obvious spread to mediastinal tissue was noted. Postoperatively the patient recovered uneventfully. Radiation and chemotherapy were planned, but the patient never regained her strength enough to tolerate adjunctive therapy.

Three months postoperatively a left pleural effusion developed which also contained malignant cells. The patient gradually deteriorated and died.

SYMPTOMS OF MALIGNANT MESOTHELIOMA. Most patients with mesothelioma complain of chest pain associated with dyspnea and weight loss of approximately six months duration.

Laboratory work is usually unremarkable.

DIAGNOSIS: Chest radiography will reveal a pleural effusion often associated with pleural nodularity or pleural plaques which may or may not be calcified.

Tissue diagnosis has been a problem. The differentiation between metastatic adenocarcinoma of pleura and mesothelioma has been difficult, but has been aided by special stains and electron microscopy.

Pleural fluid analysis and needle biopsy of the pleura are frequently nondiagnostic and open lung biopsy is often needed. In one series of 32 patients, the diagnosis was delayed for over two months in seven patients because of inconclusive pathological findings and delay in obtaining an open biopsy. Both fibrous and epithelial components are present in various degrees in the specimen.

Grossly a thick, gray-white mass compressing the bronchi and lung is found.

STAGING: Staging of the tumor has assisted in evaluation, treatment, and prognosis:[5]

STAGE I: Tumor confined to pleura, lung, and pericardium.

STAGE II: Invasion of the chest wall and mediastinum.

STAGE III: Penetration of the diaphragm and lymph node metastases.

STAGE IV: Distant metastases.

The diagnosis of malignant mesothelioma carries a dismal prognosis with very few five-year survivals. Several series average a 10-month to 12-month survival after diagnosis.

TABLE 1—*Results of surgical resection for mesothelioma*

STUDY	YEAR	NO. OF PATIENTS	TYPE OF RESECTION	% OF PATIENTS SURVIVING		
				ONE YEAR	TWO YEARS	THREE YEARS
Worn[6]	1974	186	Radical	75	34	9
		62	"Palliative"	68	37	10
Butchart[7]	1976	29	Radical	30	10	3
Wanebo[8]	1976	33	Pleurectomy	NS	30	15
DeLaria[9]	1978	11	Radical	36	27	0
Antman[10]	1980	10	Pleurectomy	70	30	10

THERAPY. Patients with STAGE I disease are treated with either pleurectomy or pleuropneumonectomy followed by radiotherapy and chemotherapy. A few five-year survivals have resulted.

As noted in Table 1, an approximate 10% three-year survival was the best that could be obtained in the listed surgical series.

Malignant mesothelioma usually spreads locally and results in death by respiratory or cardiac failure secondary to local invasion rather than metastatic disease. Mesothelioma may extend through the diaphragm into the peritoneal cavity with resultant bowel obstruction.

Palliation with radiotherapy and chemotherapy has resulted in an increased survival as compared to no treatment. Chemotherapy using doxorubicin hydrochloride (Adriamycin™) seems to be most effective.

In 1976 asbestos fibers were found in the drinking water in Duluth, Minnesota, and a careful evaluation was done to determine if an increased evidence of gastrointestinal carcinoma or peritoneal malignancy could be found. No evidence of increasing carcinoma was found as compared to other areas in the state.[11]

Current management of patients with malignant mesothelioma should be in accordance with the following protocol. Patients without extrapulmonary disease who are clinically suitable have thoracotomy and extra pleuropneumonectomy.

The importance of tissue type, epithelial versus fibrous, to survival is unknown.

If extrapulmonary disease is present, intensive radiation followed by multiple drug chemotherapy using doxorubicin hydrochloride should be considered.

SUMMARY. There will be an increasing incidence in mesothelioma during the next several years because of the delayed onset of malignant mesothelioma following asbestos exposure 20 to 30 years ago.

The most frequent finding of mesothelioma is a pleural effusion that may evade a definite diagnosis.

Although surgical cures are scarce, surgery followed by radiation and chemotherapy seems to be the best treatment at this time for STAGE I malignancies.

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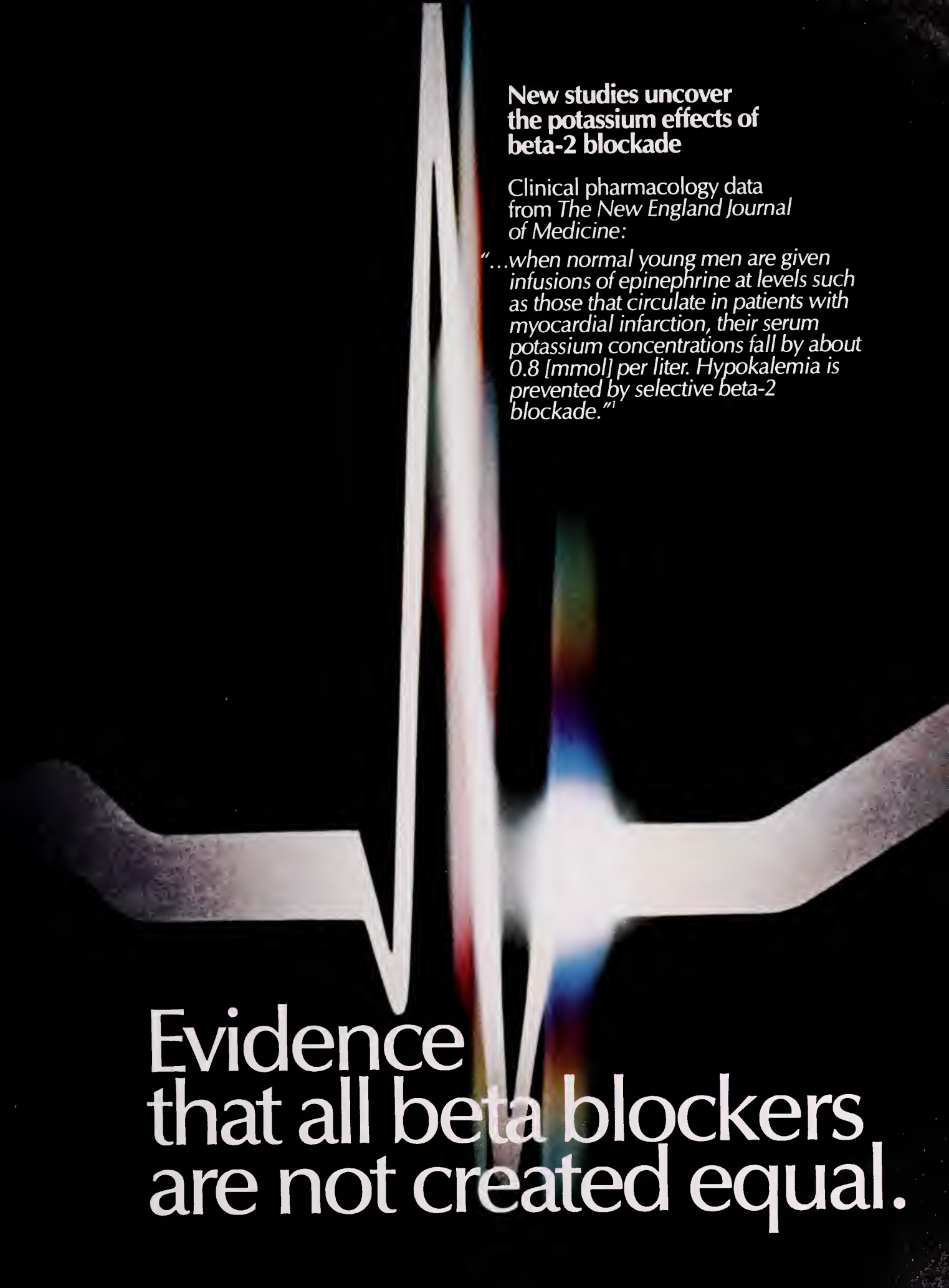
A survey showing current status of medical directors and long-term care facilities in Wisconsin

Mary Ann Zilz, RN, Madison, Wisconsin

A survey was performed to evaluate medical directors' involvement in long-term care facilities to determine: (1) current activities of the medical director as compared to standard 5 of the JCAH Accreditation Manual for Long-term Care Facilities, (2) hours of medical director involvement, and (3) reimbursement. Of the 315 questionnaires mailed, 42% (133) responded. Findings suggest that the majority of medical directors state that they are complying with the activities required. There was a wide variation in hours of work reported with an overall median of 8 hours per month. There was no relationship between the number of hours of work reported and reimbursement. Only 54% of the respondents reported that they had written job descriptions and only 50% of the respondents who sent a copy of their job description (1) clearly delineated accountability to the board [8 of 18] or administration [1 of 18] and (2) clearly defined who was responsible for liability insurance coverage [9 of 18]. Recommendations regarding job descriptions are made.

The entire article is available upon request to: Mary Ann Zilz, RN, 5126 Whitcomb Drive, Madison, Wisconsin 53711.■



New studies uncover the potassium effects of beta-2 blockade

Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.

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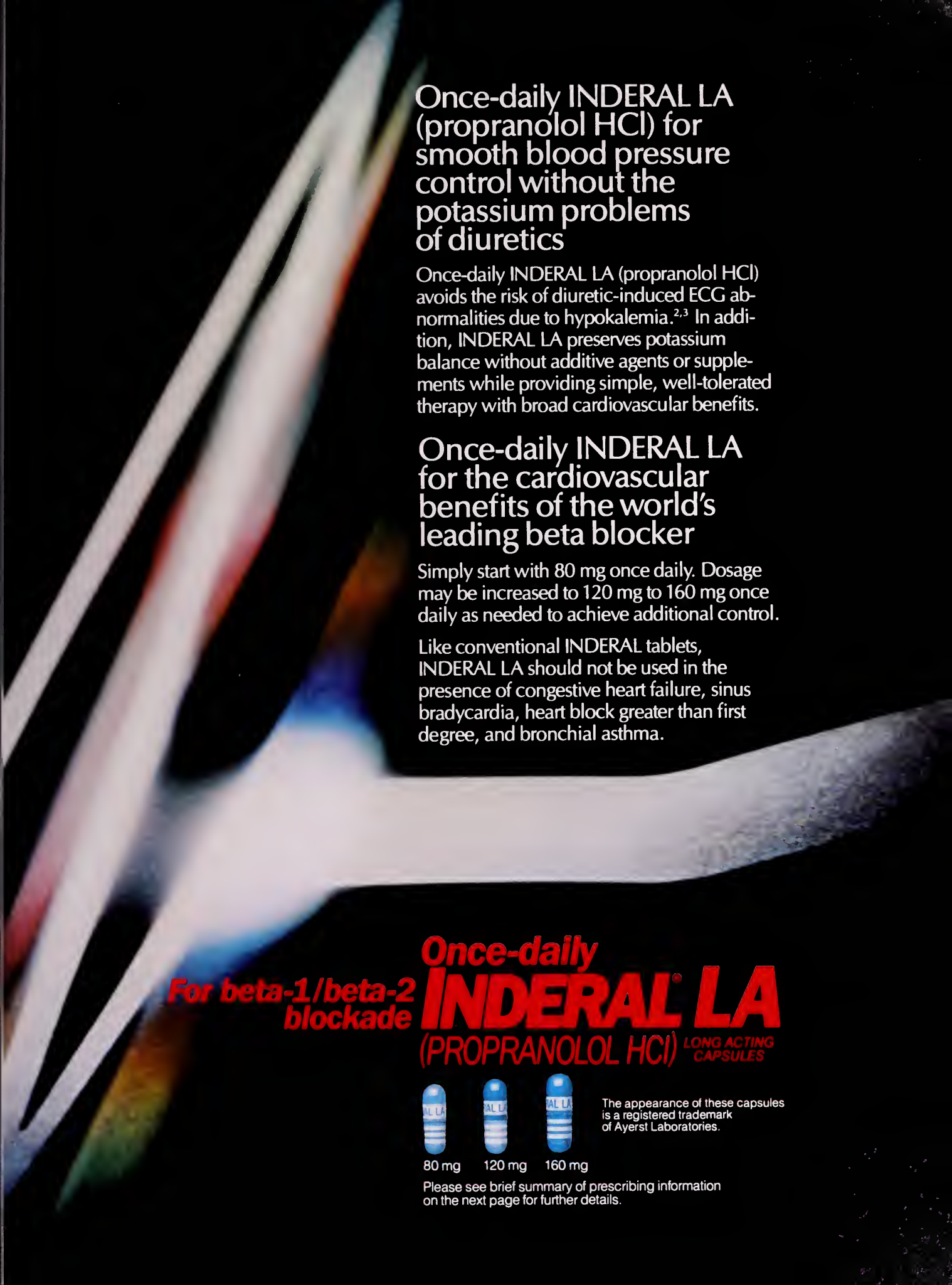


Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[2,3] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily INDERAL® LA

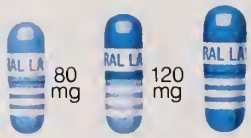
(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Autoimmune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Epstein FH, Rosa RM. Adrenergic control of serum potassium. *N Engl J Med* 1983; 309:1450-1451. **2.** Holland OB, Nixon JV, Kuhnert L. Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **3.** Holme I, Helgeland A, Hjermann I, et al. Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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SMS Annual Meeting approaching

Mark calendars now for the 1985 SMS Annual Meeting, April 25-27 in La Crosse. This year's meeting will focus on "Cost-effective Care of the Geriatric Population." Special panels will be presented dealing with economic and ethical considerations involved in caring for the elderly.

The Panel on Economics on Friday, April 26, will be moderated by Ralph Andreano, PhD, chairman of the Dept of Economics, UW-Madison. Panelists include: Jeffrey Adams, PhD, Associate Professor of Economics, Beloit College; State Senator Susan Engeleiter (R-Menomonee Falls); State Senator Russell Feingold (D-Middleton); Linda Reivitz, Secretary, Wisconsin Dept of Health and Social Services, State Representative Peggy Rosenzweig (R-Wauwatosa); Edward R Winga, MD, Gundersen Clinic, La Crosse; and Lou Turner Zellner, Deputy Commissioner, Office of the Wisconsin Commissioner of Insurance.

The Panel on Ethics and the Elderly on April 26 will be moderated by Gerald Kempthorne, MD, Spring Green. Other panelists will include: Dennis J Doherty, PhD, Acting Director of the Medical College of Wisconsin (MCW) Regional Center for the Study of Bioethics; Norman Fost, MD, MPH, Dept of Medicine, UW-Madison; Roland Herrington, MD, Milwaukee, McBride Center for the Impaired Professional, Milwaukee Psychiatric Hospital; Nicholas Owen, MD, Milwaukee, and Kenneth M Viste Jr, MD, Oshkosh.

Saturday, April 27, Patricia J Stuff, MD, Bonduel, will moderate a Panel on Osteoporosis: Prevention and Treatment. Joining Doctor Stuff on the panel will be Edmund H Duthie Jr, MD, Director of the Geriatrics Residency Program at MCW; Kay Jewell, MD, Madison; Jenifer Jowsey, PhD, Dept of Orthopaedics, University of California at Davis; Elaine A Leventhal, MD, PhD, Head of Geriatrics, Dept of Medicine, UW-Madison and Everett L Smith, PhD, Director, Biogerontology Laboratory, UW-Madison.

[See slate of nominees for SMS offices on following pages.] ■

CES Foundation announces new research trust fund

The Charitable, Educational and Scientific Foundation of the SMS announces that it has received the final distribution of a bequest from the estate of James and Clara M Joss. The trust, known as the James and Clara M Joss Memorial Research Trust, provides funding in the amount of $43,543.13 to the Foundation to be used for the purpose of grants for medical research projects. The trust has been administered since 1960 for the Dane County Medical Society Foundation for Medical Research by the First Wisconsin National Bank of Madison.

Grants are awarded for research projects on health or disease, including related research in the biological behavioral sciences. In the past grants have been awarded for research on such topics as: "Mechanisms for Cardiac Arrhythmias during Anesthesia," "The Study of Three Cord Care Regimens," and "Antibody to Extracellular Matrix Protein Causing Autoimmune Disease."

Those interested in pursuing applications for grants should contact the Foundation executive director, Kristin Bjurstrom, at CES Foundation offices at the State Medical Society in Madison. ■

THE NAVY SEARCH FOR EXCELLENCE

The United States Navy Medical Command desires physicians who want to practice medicine . . . not be business managers. The Navy offers specialists quality clinical experience and professional growth, a very comfortable lifestyle without financial and administrative worries, and the valuable time to spend with family and friends while planning the future.

- Flight Surgery
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- Otolaryngology
- Neurology
- Psychiatry
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LOCATIONS: 23 modern medical facilities located along the east and west coast, as well as nine hospitals overseas, including those in Japan, Spain, Italy and the Philippines.

BENEFITS: Varied clinical experience; 30 days annual vacation; travel benefits; full malpractice, medical/dental coverage; net starting salaries from $40,000 to $55,000; non-contributive retirement package which yields approximately $20,000 a year after 20 years of service, or $30,000 a year after 30 years.

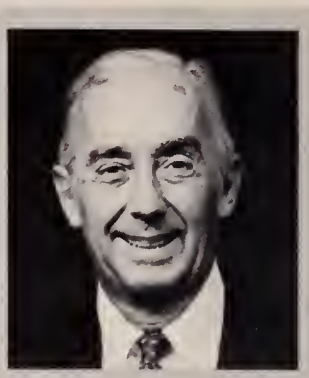
MINIMUM QUALIFICATIONS: State license; US citizen; excellent professional references.

For complete details, call or send Curriculum Vitae to: Lt Nancy Hill, Henry S Reuss Federal Plaza, 310 W Wisconsin Ave, Suite 450, Milwaukee, WI 53203; 414/291-1529 (Call Collect)

ANNUAL MEETING

Here is a slate of those candidates chosen for top State Medical Society offices by the Committee on Nominations of the House of Delegates. This is the slate on which the House will vote at the Society's Annual Meeting April 25-27 at the La Crosse Center in La Crosse. Be sure to let your county medical society delegate know your preferences in the next few weeks.

Nominees for SMS offices; election April 26



Incoming President
John K Scott, MD
Madison

Charles W Landis, MD
President-elect, SMS (1985-86)

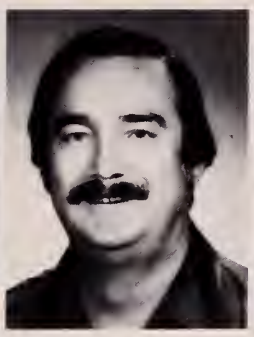
Graduated from Indiana University School of Medicine, 1951, and served internship at University of Oregon, 1951-52. Psychiatric residency, Indiana University, 1952-56. Certified in psychiatry by American Board of Psychiatry and Neurology, 1958. Doctor Landis is medical director and chief-of-staff, St Mary's Hill Hospital, Milwaukee, and also has a private practice of psychiatry. He served as president of The Medical Society of Milwaukee County in 1981 and has been a member of its Board of Directors since 1980. He has served on the mediation, ethics, and health planning committees of the Society, and also the Impaired Physician Program of Milwaukee County. He has been a member of the House of Delegates of SMS, 1962-63 and 1982-84. He has been a member of the Board of Directors since 1984. Also has been a member of the Committee on Mental Health since 1978 serving as chairman from 1978-81. He is a member of the Committee on Alcoholism and Other Drug Abuse of the State Medical Society. Has been a delegate to the Hospital Medical Staff Section of the AMA since 1983 and a member of the Steering Committee, First Congress on Mental Health, 1962. Doctor Landis is a member of the American Psychiatric Association, Wisconsin Psychiatric Association and served as president, 1962-63. Member and president, 1969-70/1979-80 of the Milwaukee Neuropsychiatric Society, and a member of the American College of Psychiatry and Central Neuropsychiatric Association. Has been associate clinical professor of psychiatry, Medical College of Wisconsin since 1971; associate professor of psychiatry and chairman, Section of Community Psychiatry, Medical College of Wisconsin, 1968-71; clinical professor of psychiatry and social welfare, University of Wisconsin-Milwaukee, 1967-70; and an instructor in psychiatry and director, Indiana University School of Medicine Child Guidance Clinic, 1956-58. Doctor Landis has served on boards or as a member of a number of civic, governmental, and professional task forces, study groups, and health organizations. Presently on board of directors of United Way of Greater Milwaukee and member of Milwaukee Rotary Club. He received the Distinguished Service Award, Medical Society of Milwaukee County in 1983, received Certificate of Commendation, American Psychiatric Association, Certificate of Appreciation for Leadership, Milwaukee County Mental Health Association, 1963, and also received the Milwaukee County Executive Proclamation honoring community service, 1983.

Duane W Taebel, MD
Speaker, House of Delegates (1985-87)

Graduate of University of Chicago School of Medicine, 1960. Internship at University of Chicago Hospital, 1960-61. Internal medicine residency at University of Chicago Hospital, 1961-64 and was chief resident in medicine, 1963-64. Fellow in gastroenterology, 1964-66, and was instructor, Dept of Medicine, University of Chicago Hospital. Served in US Army Hospital, Fort Devens, Mass, 1966-68. Received Wisconsin license in 1966 when joined Gundersen Clinic-La Crosse Lutheran Hospital. Board certified in internal medicine, 1968, and recertified in 1974. Board certified in gastroenterology, 1972. Member of Alpha Omega Alpha Honor Medical Fraternity, American Gastroenterology Association, and American Society of Gastrointestinal Endoscopy. Is Fellow, American College of Physicians. Was chairman of the Department of Medicine, Gundersen Clinic, Ltd, and has served as chief-of-staff, La Crosse Lutheran Hospital. Was president of La Crosse County Medical Society, 1976. Has been delegate to State Medical Society since 1972 and vice-speaker of the House of Delegates in 1978. Speaker, House of Delegates 1979 to present.

Doctor Taebel

Doctor Foley


Doctor Edwards

Doctor Natoli

Doctor Twelmeyer

Is chairman of Task Force Work Group on physician/hospital relations.

John J Foley, MD

Treasurer (1985-86)

Born in Chicago, Ill, he graduated from Stritch School of Medicine, Chicago, 1956. Internship and residency completed at Milwaukee County General Hospital, 1956-57 and 1959-63. Served in the United States Air Force, 1957-59. Licensed to practice medicine in Wisconsin, 1959. Certified by American Board of Surgery, and fellow of American College of Surgeons. Is member Wisconsin Surgical Society. Is assistant clinical professor of Surgery, Medical College of Wisconsin, Milwaukee. Served as SMS Councilor (now Director) from District I, 1972-1981, and as treasurer of SMS, 1981-85. Serves as *ex-officio* member of SMS Finance Committee of the Board of Directors, and is also president of Milwaukee Academy of Surgery, 1983-1985. Is a member of the Board of Directors of SMS Services, Inc.

Richard W Edwards, MD

Delegate, AMA (1986 & 1987)

Graduated from the University of Wisconsin Medical School, Madison, in 1960, and served a rotating internship at Saint Vincent's Hospital, Toledo, Ohio from 1960-61. Served in the United States Navy from 1950-54 and has been in Family Practice in Richland Center from 1961 to present. Served as president of Richland County Medical Society in 1963 and 1980 and also as delegate to the State Medical Society of Wisconsin from 1966-69. Is certified by American Board of Family Practice and also a member of the American Academy of Family Physicians. Served as chief-of-staff, Richland Hospital, Richland Center, Wisconsin in 1963 and 1980, and also was Richland County Coroner from 1966-1978. Served as Councilor of State Medical Society of Wisconsin from 1969-1978 from District II and also was vice-chairman of the SMS Council from 1976-78. He served as treasurer of SMS from 1979 to 1981. He served as chairman of the Finance Committee of SMS Council from 1972-78. From 1969-71, he was a member of the Governor's Special Task Force for Health Manpower for the State of Wisconsin and from 1976-77, he was a member of the Governor's Committee to survey health facilities in the Wisconsin State Prison System. He has been a member of the State Medical Society's Commission on Peer Review since 1969. He served as an instructor at the University of Wisconsin School of Nursing Post Graduate Program for Nurse Practitioners in 1977-80, and has been a participant in the Summer Externship Program for Freshmen Medical Students, sponsored by Wisconsin Academy of Family Physicians since 1970. Appointed assistant professor of Department of Family Medicine and Practice University of Wisconsin Medical School, 1981. Elected Family Physician of the Year 1982 by Wisconsin Academy of Family Physicians. He was an alternate delegate to AMA from 1979-1983. He presently is a delegate to AMA from Wisconsin, serving since 1984. Treasurer of SMS Services, Inc, 1979 to present. Serves as vice-chairman of the Medicaid Medical Audit Committee of the State Medical Society.

Cornelius A Natoli, MD

Delegate, AMA (1986 & 1987)

Born in Utica, New York, 1930, he received BS degree in 1952 from Niagara University, and graduated in 1956 from Georgetown University School of Medicine. Internship and residency in surgery at Barnes Hospital, St Louis, Missouri, followed by three years of urology residency at Barnes Hospital. Private practice in Salt Lake City, Utah, from 1961-1969; held offices in Utah State Medical Association, Public Health Committee, and Utah Urological Society. Member of Gundersen Clinic, Ltd, from 1969 to present. Clinical assistant professor of surgery (urology), University of Wisconsin Medical School. Is past president of La Crosse County Medical Society; member of American Urological Association, Wisconsin Urological Society, and American College of Surgeons, and North Central Section of AUA. Past chairman La Crosse County Insurance Advisory Committee; past member of SMS House of Delegates and served on its Reference Committee on Finance and chaired Reference Committee on Reports of Officers; member of past SMS Commission on Medical Care Plans, and was a member of WPS Board of Directors; past member of SMS House of Delegates Nominating Committee; and served as Third District Councilor of

Doctor Kabler

Doctor Ulmer

Doctor Viste

SMS. Is a member of WISPAC. Also member of Board of Directors, Gundersen Clinic, Ltd. Has been alternate delegate to AMA, 1979-1982, and delegate, 1983-1985.

Henry F Twelmeyer, MD

Delegate, AMA (1986 & 1987)

Graduate of Marquette University School of Medicine, Milwaukee. Received internship at Milwaukee County General Hospital, 1942 to 1943. Served residency at Milwaukee County General Hospital, 1946-1949. Received license to practice medicine in 1943 and began practice of general and vascular surgery in Milwaukee in 1950. Has been SMS alternate delegate to American Medical Association since 1971 and delegate since 1976. Chaired special committee of AMA to study meeting format, 1981-82. Was president of The Medical Society of Milwaukee County in 1971, served as member of that county's board of directors through 1974, and served as delegate to State Medical Society. Is a founding member and past president of Milwaukee Academy of Surgery, past member of Council of Wisconsin Surgical Society, and past president of Wisconsin Surgical Society. Is fellow of American College of Surgeons, past member of Council of Wisconsin Chapter of the American College of Surgeons, diplomat of American Board of Surgery, and member of Milwaukee Academy of Medicine. Is past chief-of-staff at West Allis Memorial Hospital and has been chief of surgery at both West Allis Memorial and Elmbrook Memorial hospitals. Is associate clinical professor of surgery at Medical College of Wisconsin. Is past member of Board of Directors of Surgical Care-Blue Shield and past chairman of its Operating Committee. Is also member of Wisconsin Heart Association.

J D Kabler, MD

Alternate Delegate, AMA (1986 & 1987)

Graduated from University of Kansas Medical School, 1950. Served internship and residency at University of Wisconsin Hospitals, 1950-52; 1954-56. Served in United States Navy, 1944-45; 1952-54. Board certified in internal medicine, 1958. Chief surgeon of Wisconsin National Guard 1967-1974. Subspecialty, psychosomatic medicine. Member and co-chairman, Joint Practice Committee in existence for seven years. Member and chairman, Commission on Governmental Affairs of State Medical Society, 1976-1982. Member of Board of Directors, from the First District, State Medical Society of Wisconsin, 1979-1985. Professor of Medicine, University of Wisconsin, Madison; director, University Health Services. Is presently alternate delegate to American Medical Association, 1984 and 1985.

Richard Henry Ulmer, MD

Alternate Delegate, AMA (1986 & 1987)

Graduated from Stritch School of Medicine of Loyola University, Chicago, 1961. Rotating internship, internal medicine residency, cardiology fellowship at the University of Chicago Hospitals and Clinics, 1961-69. Presently cardiologist, Marshfield Clinic, and member of the medical staff of St Joseph's Hospital, Marshfield. Clinical instructor, internal medicine, University of Wisconsin, 1969-74; clinical assistant professor, University of Wisconsin, 1974-80; clinical associate professor, University of Wisconsin, 1980 to present. Captain, United States Army, Medical Corps, 1966-68. Board certified in Internal Medicine. Member of Executive Committee, Marshfield Clinic, 1973-1975; 1982-present; secretary, Marshfield Clinic, 1973-75; treasurer, Marshfield Clinic, 1982-present; secretary, Dept of Internal Medicine, Marshfield Clinic, 1972; chief, Section of Cardiology, Marshfield Clinic, 1976, 1977; chief, Dept of Cardiology, Marshfield Clinic, 1979-80. Alternate delegate from Wood County Medical Society to SMS, 1972-73 and delegate, 1974 to present; member, Nominating Committee, House of Delegates, SMS, 1978-80; president, Wood County Medical Society, 1978 and 1985. Member of Blue Key National Honor Fraternity; Society of Sigmi Xi; American Heart Association, American Medical Association, and American College of Physicians.

Kenneth M Viste Jr, MD

Alternate Delegate, AMA (1986 & 1987)

Graduate Northwestern University Medical School, Chicago, IL, 1966. Rotating internship, Chicago Wesley Memorial Hospital, 1966-1967; NIH fellowship in neurology, 1967-1970 at Northwestern Medical School. Licensed in Wisconsin 1967. Board certified by American Board of Psychiatry and Neurology, 1975. Medical practice in Fox Valley from 1970 to present. Member of medical staff of St Agnes Hospital, Fond du Lac, and Mercy Medical Center, Oshkosh. Member of courtesy medical staffs of St Elizabeth and Appleton Memorial hospitals, Appleton; Theda-Clark Regional Medical Center, Neenah, and St Vincent Hospital, Green Bay. Teaching positions at Northwestern University Medical School, 1970; associate clinical professor of neurology, University of Wisconsin Medical School, 1972 to present; and instructor in neurology, Winnebago Mental Health Institute,

1973 to present. Has served as president, Wisconsin Neurological Society, 1977-78; delegate to State Medical Society, Winnebago County, 1972 to present; alternate delegate to AMA, 1982-present; chairman, Reference Committee on Reports of Standing Committees, State Medical Society, 1976; chairman, Nominating Committee, 1982 and member since 1975; chairman of the Physicians Alliance Commission from 1978 to present; chairman, WISPAC, 1978-1982; member of Medical Advisory Board, Wisconsin Epilepsy Society, 1974 to present; chairman, Medical Advisory Committee, Wisconsin Multiple Sclerosis Society, 1976-1982; medical director Cerebral Palsy Clinic of Winnebagoland, Oshkosh. Governor's appointee to State Health Policy and Planning Council, 1974-76; member of State Department of Transportation, Medical Review Board on Epilepsy, 1974 to present; medical director, Neurorehabilitation Units, Mercy Medical Center, Oshkosh, and St Agnes Hospital, Fond du Lac; and member of WINNEFOX Regional Library Board, Oshkosh, 1978 to present. Also member of the American Medical Association; Winnebago and Fond du Lac County Medical Societies; Fellow American Academy of Neurology; Wisconsin Neurological Society; American EEG Society; American Medical EEG Society; Chicago Neurological Society; Central Neuropsychiatric Association; American Association for the Study of Headache; and American Congress of Rehabilitation Medicine. Presently serving as an alternate delegate to American Medical Association, 1984 and 1985. ■

Timothy T Flaherty, MD

(President, State Medical Society)

Delegate, AMA (1985)

Note: The AMA Bylaws were amended in 1984 to provide for an additional delegate (and alternate delegate) from constituent state associations when 75% or more of their members are also members of AMA. SMS is eligible for this additional position in 1985 based upon the official membership count as of December 31, 1984. The House of Delegates Nominating Committee has accepted the recommendation of the Board of Directors that this additional delegate (and alternate delegate) be the president (and president-elect) of the Society. Continued eligibility for this additional seat will be determined on an annual basis by the membership count as of each December 31 and maintenance of the required percentage of AMA members. ■

House of Delegates 1984–85 Nominating Committee

DISTRICT	
1	Jerome W Fons, Jr, MD Cudahy
1	Robert F Purtell, Jr, MD Milwaukee
1	John D Riesch, MD Menomonee Falls
1	Raymond E Skupniewicz, MD Racine
2	Sandra Osborn, MD Madison
2	James J Tydrich, MD Richland Center
3	Stephen B Webster, MD La Crosse
4	John E Thompson, MD Nekoosa
5	Kenneth M Viste, Jr, MD Oshkosh
6	Robert T Schmidt, Jr, MD Green Bay
7	Merne W Asplund, MD Bloomer
8	Joseph M Jauquet, MD Ashland
SPECIALTY SECTIONS	Philip J Dougherty, MD Menomonee Falls

SMS needs MDs for committees, commissions

SMS members interested in serving on statewide committees and commissions dealing with current topics affecting medicine and public health are urged to submit their names to the SMS Secretary's Office by March 15.

Candidates should be motivated, enthusiastic, and committed to attending meetings.

Members are being sought for the following commissions and committees:

Commission on . . .
- ☐ Continuing Medical Education
- ☐ Governmental Affairs
- ☐ Health Planning
- ☐ Mediation and Peer Review
- ☐ Physicians Alliance
- ☐ Public Information
- ☐ Editorial Board, *Wisconsin Medical Journal*

Committee on . . .
- ☐ Medical Liability
- ☐ Aging and Extended Care Facilities
- ☐ Alcoholism and Other Drug Abuse
- ☐ Environmental and Occupational Health
- ☐ Health Care Costs Liaison
- ☐ Maternal and Child Health
- ☐ Medicine and Religion
- ☐ Physician-Nurse Liaison
- ☐ Mental Health
- ☐ Safe Transportation
- ☐ School Health
- ☐ Women Physicians
- ☐ Federal Legislation
- ☐ Joint Practice (SMS and Wisconsin Nurses Association

Physicians interested in serving should check the appropriate commission(s) or committee(s) and return this list to the SMS Secretary's Office at PO Box 1109, Madison, WI 53701 by March 15.

Name _____

Address _____

_____

_____

City/State/Zip Code

COUNTY MEDICAL SOCIETIES

President (P) and Secretaries (S); Executive Secretaries (ES), Treasurers (T); Executive Vice Presidents (EVP); and telephone numbers

ASHLAND-BAYFIELD-IRON
P—Mark K Belknap, MD
922 Second Avenue, West
Ashland, WI 54806
(715) 682-6651
S—David M Saarinen, MD
2101 Beaser Avenue, #2
Ashland, WI 54806

BARRON-WASHBURN-BURNETT
P—Donald E Riemer, MD
PO Box 127
Cumberland, WI 54829
(715) 822-2231
S—Roger F Macy, MD
PO Box 127
Cumberland, WI 54829
(715) 822-2231

BROWN
P—James R Mattson, MD
501 S Military Avenue
Green Bay, WI 54303
S—Stephen D Hathway, MD
PO Box 1700
Green Bay, WI 54305
(414) 433-3653
T—Roger C Wargin, MD
613 Ridgeview Court
Green Bay, WI 54303
(414) 499-8859

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P—Badri N Ganju, MD
451 E Brooklyn Street
Chilton, WI 53014
(414) 849-2888
S—James C Pinney, MD
507-C West Main Street
Hilbert, WI 54129
(414) 853-3534

CHIPPEWA
P—Richard C Sazama, MD
3203 Stein Blvd
Eau Claire, WI 54701
(715) 835-6548
S—Robert S Lea, MD
1102 Dover Street
Chippewa Falls, WI 54729

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216 Sunset Place
Neillsville, WI 54456
(715) 743-3231
S—Vangala J Reddy, MD
216 Sunset Place
Neillsville, WI 54456
(715) 743-3101

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(608) 742-8389
S—Paul J Slavik, MD
916 Silver Lake Drive
Portage, WI 53901
ES—Mrs Elayne Hanson
PO Box 352
Portage, WI 53901
(608) 742-2410

CRAWFORD
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(608) 326-6978
S—Michael S Garrity, MD
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Prairie du Chien, WI 53821
(608) 326-6466

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(414) 887-7101

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S—William Faller, MD
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S—Stanley G Norman, MD
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S—Elizabeth T Sanfelippo, MD
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Fond du Lac, WI 54935
T—Robert H House, MD
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Robert E Stader, MD
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Lancaster, WI 53813
(608) 723-2131

GREEN
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S—Jacob George, MD
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(608) 328-7000

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S—Michael E Tieman, MD
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S—Edward J Hoy, MD
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JUNEAU
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S—Nancy E B Ness, MD
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S—Thomas P Lathrop, MD
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S—John R Myers, MD
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(715) 623-3761

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S—Gail M Amundson, MD
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S—Leonard H Wurman, MD
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ES—Ms Lorraine W Kordas
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S—Leonard R Worden, MD
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S—Donald P Davis, MD
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EVP—Mr William B Harlan
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Milwaukee, WI 53202

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S—Jack D Brown, MD
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(608) 269-6731

OCONTO
P—John S Honish, MD
PO Box 260
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S—Clyde E Siefert, MD
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(715) 483-3221
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S—Roy E Buck, MD
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WOOD
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400 Dewey Street
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(715) 421-3444
S—Michael J Kryda, MD
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Marshfield, WI 54449
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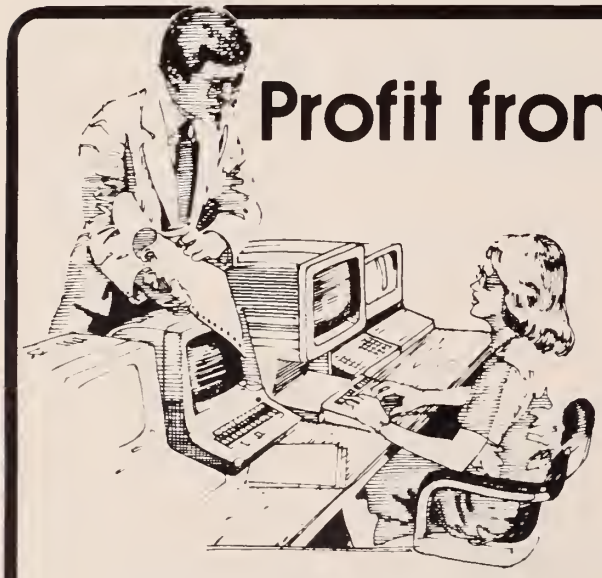

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Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1984 Membership Directory as published in the July 1984 issue of the *Wisconsin Medical Journal*. Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership records. County transfers will be included when processing has been completed by the Membership Department.

New, reelected, or reinstated members
(complete information)

Changes in specialties and/or Board certification(*)
(changes only with member's name)

By county medical society

ASHLAND-BAYFIELD-IRON

GS
Nibler, James G
206 Sixth Ave, West
Ashland WI 54806

DANE

OTO
Bartel, Thad E
600 Highland Ave
Madison WI 53792

Dolinski, Sylna Yvonne
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Madison WI 53705

Edwards, Mark L
4713 Jenewein Rd, #2
Madison WI 53711

IM CD
Effron, Barry A
4 Dunraven Ct
Madison WI 53705

Hirsch, Thomas J
1313 Fish Hatchery Rd
Madison WI 53715

Karlin, Elizabeth
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Madison WI 53705

OPH*
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5003 Monona Dr
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FP*
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Sun Prairie WI 53590

DOOR KEWAUNEE

Gwinn, Rodney P
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Sturgeon Bay WI 54235

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AN
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Monroe WI 53566

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CHP
Craft, Polly H
POB 1997
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Milwaukee WI 53217

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PH FP
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Muskego WI 53150

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Rusch, James R
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AN
Santelle, Susan L
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continued

MILWAUKEE *continued*

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FP
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Egge, Paul R
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Holzberger, James A
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D
Kingsley, David N
1603 South Locust, #207
Marshfield WI 54449

ORS HS
Torkelson, Erik O
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Reform malpractice system to cut costs, Medical Society tells Legislature

Major reform of the medical liability system in Wisconsin and elimination of mandated benefits in health insurance policies were two recommendations for controlling healthcare costs the President of the State Medical Society gave to a special joint hearing of the Legislature January 22.

The Assembly and Senate Health Committees called the meeting to hear suggestions from key healthcare groups about what can be done to contain healthcare costs in Wisconsin.

"Physician premiums for medical liability insurance have grown to the point that some physician specialties are now required to pay in excess of $25,000 per year for insurance, and these costs may well increase 75% to 100% this year alone," President Timothy Flaherty, MD, Neenah, told the legislators. "In most instances these costs are passed on to patients through higher fees."

Doctor Flaherty

Doctor Flaherty also pointed out "that upwards of 30% of the cost of physician services may be attributable to the practice of 'defensive medicine,' or prescribing additional diagnostic tests and treatment procedures in response to the increased risk of a liability action."

He urged the Legislature to carefully consider the recommendations the State Medical Society has made to the Legislative Council's Special Committee on Medical Malpractice to address the malpractice problem and the tort system in general.

Healthcare costs could also be reduced if the Legislature eliminated all mandated benefits and provider groups from insurance plans sold in Wisconsin, according to Doctor Flaherty. "Health insurance plans should be tailored to an individual's needs," he said. "No one should be required to pay for benefits that he or she doesn't want or need."

President Flaherty also urged the repeal of the Wisconsin Certificate-of-Need/Capital Expenditure Review Law. "While the law was initially implemented with the intent of preventing the duplication of healthcare services and constraining the construction of new healthcare facilities, studies now question the program's ability to contain costs," Doctor Flaherty said noting that some studies show that the CON program has contributed to the cost problem by limiting the entry of providers into the healthcare marketplace.

"The current competitive marketplace in healthcare and the new hospital rate setting commission eliminate any last remaining need for CON," he said.

Doctor Flaherty reminded the legislators that the physicians in the State Medical Society in recent months have recommended no increase in fees to the elderly and that physicians reduce or waive fees for low-income elderly. In addition, for the past several months Society physicians have provided thousands of dollars in free care through free clinics and the ShareCare program—a statewide program providing healthcare services to the unemployed. The Society has also promoted a policy of price disclosure by physicians.

"As cost containment pressures continue," Doctor Flaherty said, "we should remain mindful of the need to provide quality medical care to those who lack the financial resources to obtain that care themselves."■

Uncompensated care problem looms on horizon, SMS President says

Providing healthcare for the uninsured and others who cannot afford it is a growing problem because of tightening reimbursement to hospitals and physicians, SMS President Timothy Flaherty, MD said at a January 24 conference on Health Care and the Uninsured. The conference, sponsored by the Center for Public Representation, was aimed at health organizations, business and labor groups, consumer advocacy organizations, and representatives of state government. *continued*

continued

"New Medicare and Medicaid payment mechanisms with an emphasis on reducing costs, HMO/PPO contracts, discounts by hospitals and other cost-cutting pressures have served to reduce, and in some cases, eliminate the hospital's and physician's ability to provide free or reduced-rate care to those people who need it," said Doctor Flaherty.

Traditionally, hospitals have subsidized uncompensated care through rates charged to patients who use hospital services, according to Doctor Flaherty. He compared this to "a town that is trying to run its Fire Dept by charging only those people who have fires."

Doctor Flaherty emphasized that any proposed solution to this problem must:

- Incorporate a "means test" to insure that public dollars are not used to subsidize the non-poor who choose not to spend money on healthcare;
- Retain freedom of choice in allowing patients to select healthcare providers and institutions;
- Avoid "first-dollar" coverage problems by requiring some copayment, even if only a nominal amount, and
- Avoid the development of an overly complex, bureaucratic system which would add greatly to the cost as well as discourage provider and recipient participation.■

Malpractice committee backs SMS peer review proposal

The Legislative Council Special Committee on Medical Malpractice continued to sift through proposed revisions in medical liability laws in December and January. In an attempt to strengthen physician peer review, the Committee December 19 approved a State Medical Society proposal to create physician committees to work with the Wisconsin Health Care Liability Insurance Plan (WHCLIP), (and all other primary insurers), the Patients Compensation Fund, and the Medical Examining Board in reviewing physicians against whom multiple awards/settlements have been made. Also in this regard, the Committee voted to increase protections from lawsuits for physicians serving on peer review committees.

In addition, the Committee voted to make the following changes in the Patient Compensation Panels:

- Hold separate hearings on the issues of liability and damages. Only if negligence is found at the initial hearing would the Panel reconvene to consider damages.
- Not require expert testimony at panel hearings.

At its January 28 meeting the Committee approved an SMS recommendation that the losing party in a panel case must post a $10,000 bond if pursuing a panel case in circuit court.

Also at the meeting the Committee rejected proposals:

—To require physician consent prior to an insurance company settling a claim; and

—To make panel findings binding.

At previous meetings the Committee voted to limit malpractice awards to $1 million per occurrence and limit attorney contingency fees.■

WHCLIP Fund rate increases recommended

The Actuarial Committee for the Wisconsin Health Care Liability Insurance Plan (WHCLIP) and the Patients Compensation Fund are recommending a 69.6% increase in WHCLIP rates and a 160% increase in the Patients Compensation Fund assessment to be effective July 1, 1985. The recommendation was to be finalized by the WHCLIP Fund Board of Governors at its meeting February 13. The increase in the Fund assessment is intended to cover next year's claims and recover a portion of the projected $74.7 million deficit.

If a physician chooses to obtain basic coverage from WHCLIP, the total premium for liability coverage (WHCLIP plus the Fund) will range from $4,792 for a family physician to $51,773 for a neurosurgeon.

SMS actuaries opposed the increases as being excessive. The SMS Committee on Medical Liability and the Board of Directors are reviewing this proposal and formulating a plan of action.■

Medicare participating physicians' directories available

WPS-Medicare recently released the Medicare Participating Physician Directory which provides a list by city of all MDs, hospitals, and other services who signed up as "participating physicians." It also issued the latest Participation List (PARL) which indicates the percentage of cases

continued

continued
in which each physician accepts assignment. Persons wishing to obtain these directories can submit their request with the appropriate check to: WPS-Medicare, ATTN: Edie Laufenberg, PO Box 1787, Madison, WI 53701.

MEDPARD (Milwaukee, Waukesha, Racine, Kenosha, Washington Ozaukee counties): $4.62

MEDPARD (Balance of state): $4.42

PARL (Entire state): $25.00

SMS is currently analyzing the directories to determine the actual breakdown of participating physicians by city, specialty, and county medical society. According to the SMS review, 2,691 physicians have agreed to participating status. If physicians have specific questions about the directory or the situation in their county or city, they are encouraged to call Brian Jensen or Michelle Scoville of the SMS Physicians Alliance Division at 1-800-362-9080 or (608) 257-6781.

Physicians also might be interested in this comparative data compiled by the Health Care Financing Administration before implementation of the Deficit Reduction Act:

—87% of all physicians saw Medicare patients or received some Medicare funding.

—80% of those physicians accepted assignments some of the time.

—20% of those physicians always accepted assignment.

—51% of all Medicare claims were assigned.■

Legislative leadership announced

Senate and Assembly leaders and committees have been chosen for the 1985 Legislature. Key legislative leaders for 1985 are: Senate Majority Leader Tim Cullen (D-Janesville); Senate Minority Leader Susan Engeleiter (R-Menomonee Falls); Assembly Majority Leader Dismas Becker (D-Milwaukee); Assembly Minority Leader Tommy Thompson (R-Elroy); Assembly Speaker Tom Loftus (D-Sun Prairie); and Senate President Fred Risser (D-Madison).

Committee appointments of concern to physicians include:

Joint Committee on Finance: Representatives Schneider (D-Wisconsin Rapids) (Chair); Metz (D-Green Bay); D Travis (D-Madison); Jauch (D-Superior); Kunicki (D-Milwaukee); Nelson (R-Milwaukee); Prosser (R-Appleton); Panzer (R-West Bend); Senators George (D-Milwaukee); Norquist (D-Milwaukee); Roshell (D-Eau Claire); Chvala (D-Monona); Helbach (D-Stevens Point); Strohl (D-Racine); Stitt (R-Port Washington); Chilsen (R-Wausau).

Assembly Health & Human Services: Representatives Robinson (D-Wausau) (Chair); Barrett (D-Milwaukee); Medinger (D-La Crosse); M Coggs (D-Milwaukee); Bell (D-Milwaukee); Holperin (D-Eagle River); Black (D-Madison); J Young (R-Brookfield; Rosenzweig (R-Wauwatosa); Ourada (R-Antigo); Johnsrud (R-Eastman).

Senate Agriculture, Health and Human Services: Senators Moen (D-Whitehall) (Chair); Otte (D-Sheboygan); Feingold (D-Middleton); Ulichny (D-Milwaukee); Norquist (D-Milwaukee); Lorman (R-Fort Atkinson); Rude (R-Coon Valley); Harsdorf (R-Beldenville).

Senate Labor, Business, Veterans Affairs and Insurance: Senators Van Sistine (D-Green Bay) (Chair); Roshell (D-Eau Claire); Otte (D-Sheboygan); Plewa (D-Milwaukee); Leean (R-Waupaca); Kreul (R-Platteville).■

Annual Meeting resolution deadline

The 1985 House of Delegates sessions will be held April 25-26 in La Crosse. All resolutions must be submitted in proper form to the Secretary's office at SMS no later than February 25, 1985 (two months prior to the first session of the House). It is important that county medical societies, specialty sections, and members submit resolutions early to facilitate early distribution of materials and allow all delegates to adequately represent their county medical society or specialty section. If a resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS staff is available to assist in preparation of fiscal notes. The first session of the House will convene on April 25 and the second and third sessions will be on April 26, 1985. ■

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

wispac

William L Treacy, MD; Chairman
WISPAC Board of Directors

What is WISPAC?

The Wisconsin Physicians Political Action Committee is a voluntary, nonprofit organization whose membership consists of physicians and their spouses. Restricted from making political contributions, the State Medical Society created and administers WISPAC to provide the medical profession with an opportunity to assume a more active role in the political process.

Why is WISPAC necessary?

Most physicians would rather stay out of politics but unfortunately, government doesn't feel that way about getting involved in medicine. Medical liability, cost and competition regulations, as well as proposals dealing with lay midwifery, living wills, and mandated insurance coverages are just a few of the issues that the Legislature will be dealing with during the 1985-86 session. It's essential that physicians support those legislators who understand and are responsive to medicine's concerns.

Was WISPAC successful in last year's election?

Yes. In the November election WISPAC endorsed the eventual winner in 86 out of 99 Assembly races and in 14 out of 17 Senate races. Maybe even more importantly, WISPAC was able to get off to a good start with many new legislators. In 75 percent of the cases where there was no incumbent running, WISPAC supported the winning candidate, thus, strengthening medicine's position in the legislative forum. Over 60 percent of those candidates endorsed by WISPAC accepted direct financial contributions while the others received various types of assistance in their campaigns.

What about Federal elections?

WISPAC traditionally concentrates on the state legislature and cooperates with the American Medical Political Action Committee on the national level. AMPAC has more than 50,000 members throughout the country and supports campaigns for the US Senate and Congress. Wisconsin has an extremely good record for getting AMPAC funds back to districts in this state.

Does WISPAC favor one political party over another?

No, in fact, over the last three elections, neither the Republican nor Democratic party candidates have received more than 52 percent of the endorsements made by WISPAC.

How does WISPAC target its support?

Support is given to individuals based on their voting records, their indicated support for medicine, and realistic political appraisals. The final decisions are made by the WISPAC Board of Directors after carefully looking at all the facts, and in many cases, relying heavily on the recommendations of physicians who have attended local legislative meetings.

What will WISPAC be doing in 1985?

Political action must not end with the elections. WISPAC will continue to play an important role during this year's legislative session, coordinating fundraisers, other local political activities, and most importantly physician-legislator contacts. For the first time this year, we've asked some key legislative leaders to offer comments on healthcare issues and they are being featured in a series of *Campaign Insight* newsletters. And finally, we're looking forward to chances such as this, to provide physicians throughout the state with more information about WISPAC, and politics in Wisconsin.■

Harold D Rose, MD, Wood, died Feb 8, 1984 in Wood. Doctor Rose was born in 1924 and graduated from George Washington University School of Medicine in 1948.

Ralph George Burnett, MD, 53, Kenosha, died Aug 27, 1984 in Kenosha. Born June 10, 1931 in Kenosha, Doctor Burnett graduated from Marquette University School of Medicine in 1956 and completed his internship at Cook County Hospital in Chicago. He served in the United States Navy from 1957-1959. He was a member of Kenosha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow and six children.

Bernard Anthony Trimborn, MD, 71, Milwaukee, died Oct 3, 1984 in Milwaukee. Born July 23, 1913 in Milwaukee, Doctor Trimborn graduated from Marquette University School of Medicine, Milwaukee, in 1938 and served his internship at St Joseph's Hospital in Milwaukee. His residency was completed at St Michael's Hospital, Milwaukee. Doctor Trimborn was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving is his widow.

Oscar A Stiennon, MD, 94, Green Bay, died Dec 7, 1984 in Green Bay. Born on Sept 19, 1890 in Belgium, Doctor Stiennon graduated from Marquette University School of Medicine in 1918 and served his internship at Milwaukee County General Hospital. Doctor Stiennon had practiced medicine in Green Bay since 1919 and was a member of the medical staff of St Vincent's, Bellin, and St Mary's hospitals. He served as a delegate from the Brown County Medical Society for twelve years and also was a past president of Brown County Medical Society. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin, and also was a member of the American Medical Association. Surviving are two sons, Dr O Arthur Stiennon and John J Stiennon of Madison.

Raul M Lagman, MD, 54, Cuba City, died Dec 19, 1984 in Cuba City. Born Apr 15, 1930 in Manila, The Philippines, Doctor Lagman graduated from the University of Santo Tomas in 1957 and completed his internship at Sacred Heart Hospital in Spokane, Wash. His residency was completed at the Tucson Hospital Medical Center in Arizona. Doctor Lagman had been associated with the Cuba City Medical Center since 1971. He also had been associated with the Southwest Health Center in Platteville. Doctor Lagman was a member of the Grant County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Charlotte; four sons, Steve, Madison; Matt, Mike, and Bruce all of Phoenix, Ariz; two daughters, Mary and Kim, Mesa, Ariz; and two stepchildren, Shawn and Kami Kratochvill of Cuba City. ■

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CONTRIBUTIONS—December 1984

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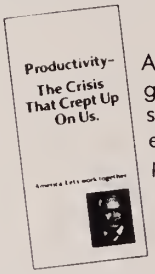

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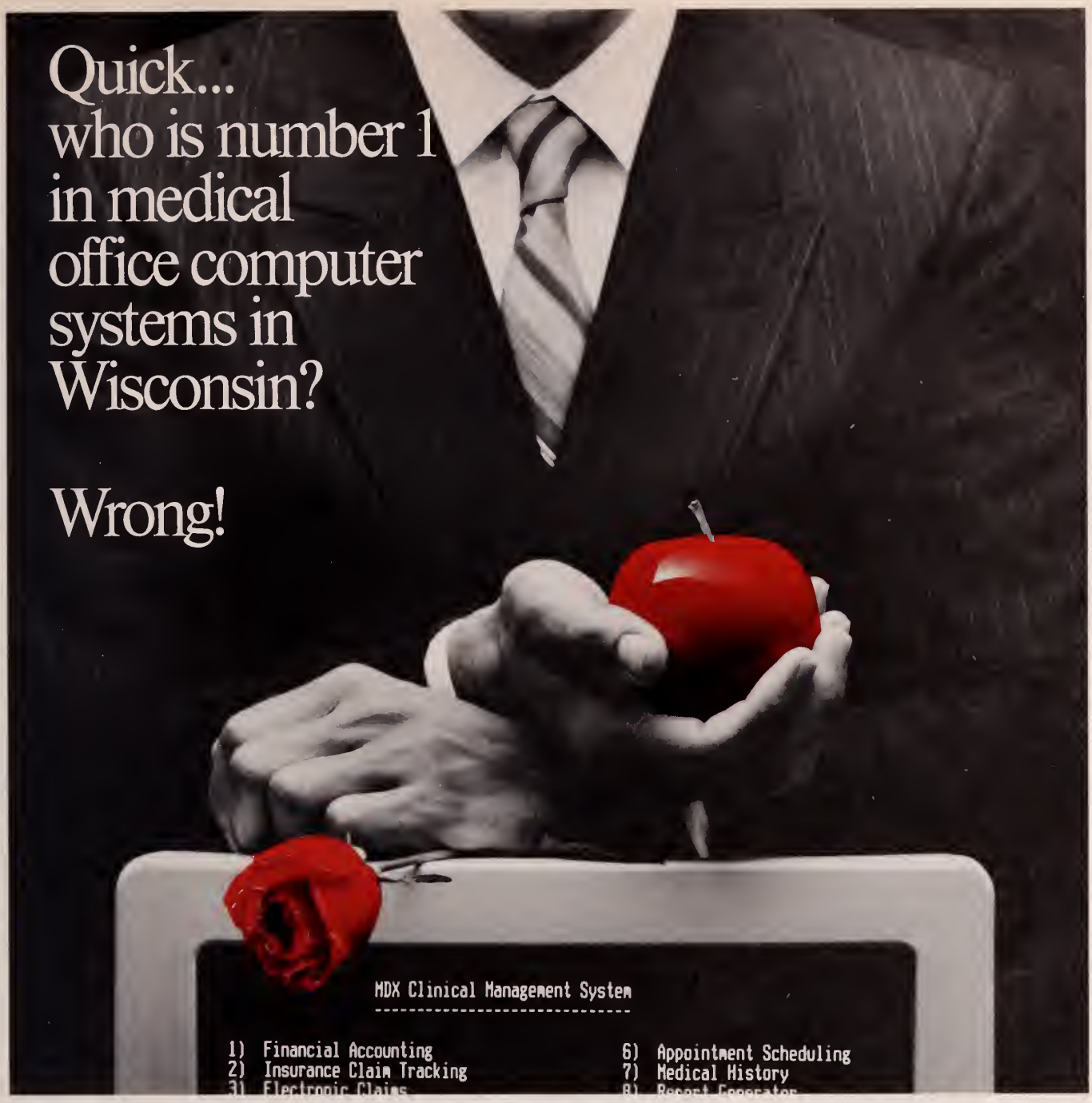

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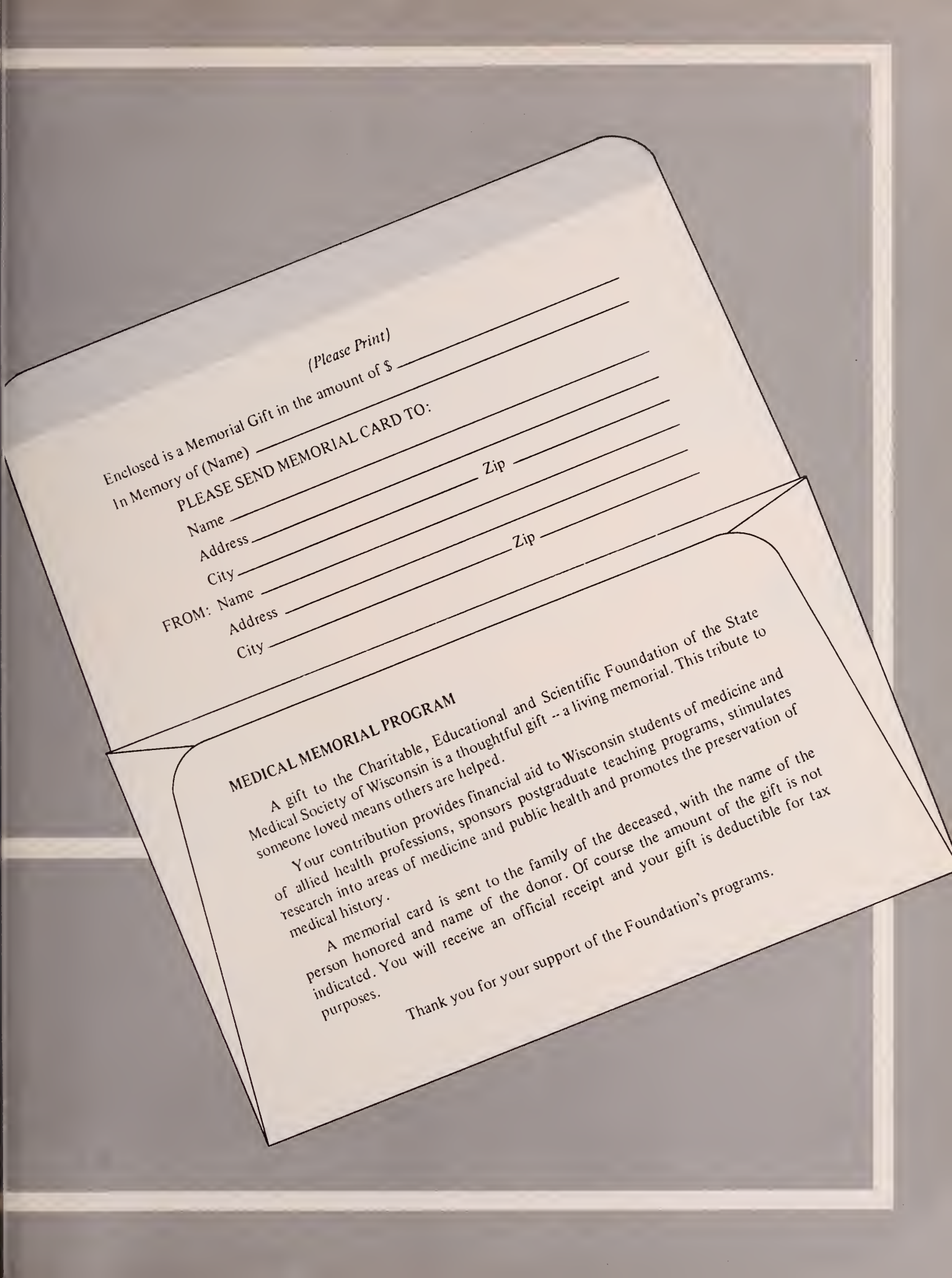
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New Baby Doe rules proposed

The Reagan Administration has proposed new rules which require treatment of handicapped infants except in extreme cases. The rules implement the Child Abuse and Prevention and Treatment Act, which require treatment and nutrition for all handicapped infants except when the infant is irreversibly comatose. The treatment would merely prolong dying; or the treatment would not prolong the infants' life and would therefore be "inhumane."

The rules state that the decision to treat a handicapped infant must "be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved . . . It is not to be based on subjective 'quality of life' or other abstract concepts."

Under the rules, state child abuse agencies must investigate complaints of medical neglect; and in order for states to receive federal funds for their child abuse programs, they must have programs in place by October 9, 1985 to respond to complaints, coordinate with the hospital ethics review boards, help parents, and go to court if necessary.

The AMA opposes the rules on the grounds that families have the right to make a decision about the nature of their child's treatment. The AMA says it will challenge the implementation of the legislation when it violates those rights.

The new rules differ from the regulations which were struck down by courts earlier this year in that they are not based on laws prohibiting discrimination against the handicapped, they do not require that handicapped infants be provided with the same care as nonhandicapped children. The rules do say that handicapped children be provided the best care for their circumstances and admit that there are circumstances where no care is the best course. They do not require federal intervention when medical neglect is suspected.■

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SMS seeking repeal of rule allowing chiropractors to draw blood

The State Medical Society appealed to the Legislature's Joint Committee for Review of Administrative Rules January 16 to repeal a new Chiropractic Examining Board rule which gives chiropractors the authority to draw blood for diagnostic purposes. The Society is asking JCRAR to hold a hearing and seek repeal of this rule on the grounds that the Medical Practice Act in Wisconsin clearly prohibits chiropractors, or anyone who is not a licensed physician, from drawing blood.

"The Chiropractic Board is not empowered to expand chiropractic scope of practice into the medical arena or elsewhere simply because its appointed members conclude the collective profession has expertise in a new procedure," SMS told JCRAR co-chairman Senator John Plewa (D-Milwaukee) and Representative Steven Brist (D-Chippewa Falls).

"More thought is needed before chiropractors are authorized to draw and analyze blood," SMS said. "First of all, is the knowledge to do so real or alleged, and secondly, does such a procedure really fit into a practice that heals by remedying interferences in nerve transmission? Our opinion is that there is no public benefit derived from this authorization, but it could pose some risk to public health."■

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No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

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Talwin® Nx

IV Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

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Please see following page for Brief Summary.

Talwin® Nx® IV

Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone

TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions. Usage with Alcohol.* See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility.* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C.* Should be given to pregnant women only if clearly needed. *Labor and Delivery.* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular:* Hypotension, tachycardia, syncope. *Respiratory:* Rarely, respiratory depression. *CNS Acute CNS Manifestations.* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic:* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other:* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

Please consult full product information before prescribing.

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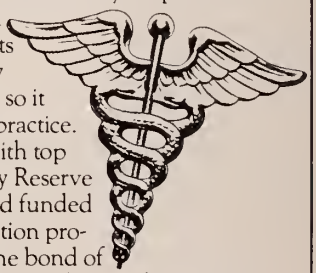

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CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

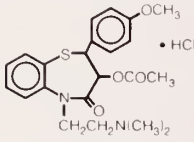
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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Brown County residents give high marks to area medical care

BROWN: Residents of Brown County feel they receive a high level of quality care but that something still has to be done to decrease healthcare costs, according to a recent public opinion survey conducted by the Brown County Medical Society and the University of Wisconsin-Green Bay.

The survey was a result of a collaborative effort between the Brown County Medical Society and a University of Wisconsin-Green Bay marketing class interested in conducting the survey as a class project. Lee Richardson, MD,* Green Bay, organized the project on behalf of the county medical society and worked with the university to determine what type of information should be sought by the survey.

Questions were developed to determine: overall patient satisfaction with medical care in Brown County, perceived problem areas, and patient awareness of medical services available in the community.

Findings of the survey included these highlights:

- Brown County residents visit a physician at about the same rate as the national average.
- Less than 25% of respondents have changed physicians in the last three years, and that the primary reasons for changing physicians were patient relocation, and dissatisfaction with care received (was not satisfied, seldom saw own doctor, didn't care for manner, or long wait). In this case, the study confirmed what was already suspected: patients who are dissatisfied with their physicians' services will change to a different doctor.
- People feel the cost of Brown County medical services is equal to statewide costs, and that the quality of medical care is high when compared to the price. The conclusion: people are basically satisfied with the quality of available healthcare.

Availability of medical services is basically not a problem in Brown County. Only 14.6% of respondents went outside the county for care with the most frequent reasons being consultation (or referral) and the reputation of outside institutions or doctors.

Emergency room service is the category of care needing the most improvement; however, even though it had the lowest satisfaction rate, 87% ranked it average or higher.

More than 70% of Brown County residents surveyed were aware of medical services such as the Free Clinic, County Immunization Program, Planned Parenthood, Private Physician, Emergency Room, Clinic, Hospital Outpatient Services. Only 30.2% were aware of Company Clinics; Emergency Room and Private Physician Services showed the highest level of awareness, with 83% and 96% respectively.

Eighteen percent of the respondents felt "more doctors" is the addition most needed in existing Brown County medical care.

In response to the study findings, the county medical society also developed several recommendations for action by local physicians. They included:

- Although most Brown County residents already feel the quality of healthcare is high compared to price, this belief needs to be continually reinforced. Physicians must continue to provide a high quality service.
- People feel the improvement most needed is lower cost. While recognizing that technological advancements may necessitate higher fees, medical professionals must begin to balance the additional benefits against the additional cost. Physicians must also begin to evaluate the current healthcare system and find ways to decrease both time and cost inefficiencies. Failure to do so can only lead to an increase in competition, government intervention, and alternative methods of delivering these services.

Since a large number of people indicated they do not know how the cost of medical services in Brown County compares with a statewide cost, it is recommended that measures be taken to educate the public on this matter. This would be a particular benefit if costs are indeed lower in Brown County than elsewhere.

A significant number of residents feel more doctors are needed. If this judgment is accurate, efforts should be made to attract more doctors to Brown County. If this judgment is inaccurate, it indicates that physicians currently practicing in the area need to make themselves more available to patients.

- Based on respondents' evaluations, emergency room service needs improvement. The county medical society can only suggest further study of these services since this study did not deal with emergency room care in detail.
- Further study is also recommended to determine the exact causes for dissatisfaction with private physician care as indi-

continued

continued

cated by those who had changed doctors. Physicians need to be more responsive to the needs of these patients. Doctors who are concerned about this might consider using a brief survey of their own patients to determine dissatisfactions pertaining to their own practice.

BROWN: At the December meeting of the Brown County Medical Society, 55 members and guests were present to hear the Most Reverend Adam Maida, Bishop of Green Bay, speak on "Technology and Medical Practice." The following physicians were accepted to membership: MDs Jules H Blank;* Thomas P. Koehler;* and David L Samuel.*

EAU CLAIRE - DUNN - PEPIN: At the November meeting of the Eau Claire-Dunn-Pepin County Medical Society, Paul Jacobson, SMS Physicians Alliance field consultant, discussed physician licensure regarding CME credits and also medical malpractice suits and cases. Elected to office for 1985 were MDs Patrick W Connerly,* president; Michael F Finkel,* vice president; Stanley G Norman,* secretary-treasurer; Karl E Walter,* Thomas E Pederson,* James E Willard,* and Daniel F Johnson,* delegates to SMS, with Peter H Ullrich* and Verne A Sperry* as alternate delegates.

JEFFERSON: Twenty-three members and guests were present at the December meeting of the Jefferson County Medical Society. The following officers were elected for 1985. They are MDs Alan L Detwiler,* Fort Atkinson, president; Brigido C Calado,* Watertown, vice president; and Edward J Hoy,* Watertown, secretary-treasurer. The Society sent $500 to the American Red Cross for the African Food Project through the University of Wisconsin-Whitewater, and also the Toddler Car Safety Seat Loaner Program at Fort Atkinson Memorial and Watertown Memorial hospitals; both received checks for $200 to buy more seats.

OUTAGAMIE: Twenty members were present at the November meeting of the Outagamie County Medical Society. Rick Reas, executive assistant of the SMS Physicians Alliance Division, spoke on the "Current Status of the Malpractice Situation in Wisconsin." Charles E Larson, MD, who transferred from the Hennepin County Medical Society in Minneapolis, Minn, was accepted into membership of the Society.

OUTAGAMIE: Andrew D Burish, Madison, Account Executive of Paine Webber Inc, spoke on "Financial Planning and Tax Shelters." Retired membership status was approved for MDs William A Dafoe* and James C Curry;* and Jill P Harman, MD,* Appleton, a transfer from Portage County, was accepted into membership.

MARINETTE - FLORENCE: Twenty-four members were present at the January meeting of the Marinette-Florence County Medical Society to hear Edward Percy, MD, Director of Sports Medicine at the University of Arizona in Tucson, speak on "Sports Medicine—What Is It?"

MONROE: The January meeting of the Monroe County Medical Society met in Tomah on January 17. Thomas N Roberts, MD, La Crosse, spoke on "Reyes Syndrome."

WINNEBAGO: Forty members and one guest were present at the January meeting of the Winnebago County Medical Society. Brian Jensen, Director of the SMS Physicians Alliance Division, spoke on "Politics in Medicine in Wisconsin." A question and answer session followed the presentation. Harold J Danforth, MD,* Oshkosh, was approved for retired status in the membership of the Society. ■

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"WATS" LINE FOR MEMBERS

The in-WATS (toll-free) line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

1985
ANNUAL MEETING
APRIL 25-27
LA CROSSE

PHYSICIANS EXCHANGE

Internal Medicine. Join multispecialty group of nine physicians in Sturgeon Bay, Wisconsin. Primary care, consultations. Modern 110-bed hospital. Attractive financial package. Live in beautiful Door County. Charles Nelson, Fox Hill Associates, 250 Regency Court, Waukesha, Wisconsin 53186; ph 414/785-6500 collect. p2-3/85

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

General Surgeon. Board certified or eligible to replace retiring surgeon in 16-physician multispecialty group practice (2 surgeons, 2 Ob/Gyn, 6 internists and 6 pediatricians). Two-year salary guarantee with full partnership available at beginning of third year. Send CV to T E Flood, Administrator, Beaumont Clinic, Ltd, 1821 So Webster Ave, Green Bay, WI 54301. p2-4/85

Family Practice Physicians. Opportunity available at the Grafton Clinic, an affiliate of St Luke's Samaritan Health Care, Inc, for Board certified or eligible family practice physicians. Join our growing primary care clinic which emphasizes the total family's health care needs. Position offers excellent salary and benefit package. The Grafton-Cedarburg area is located 20 miles northwest of Milwaukee, offering you country living near a large metropolitan city. Inquiries or curriculum vitae should be directed to Mr H Derewicz, Vice President, Good Samaritan Medical Center, 2224 West Kilbourn Avenue, Milwaukee, WI 53233 or call 414/344-3840. 2/85

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DEADLINE: Copy must be received by the 15th of the month preceding month of issue; e.g., copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Director–Medical Services. Bureau of Correctional Health Services Wisconsin Division of Health. Physician for full-time administrative and clinical practice. Board certified or eligible in family practice, internal or preventive medicine. Duties include supervising physicians who provide care in correctional institutions, developing policies and procedures within available resources to assure quality of care consistent with community standards, devoting approximately 45 per cent of time in direct clinical involvement at correctional facilities, and other related tasks. Competitive salary and extensive fringe benefits. Must possess or be eligible for a Wisconsin license. Contact: Barbara Whitmore, Director, Bureau of Correctional Health Services, PO Box 309, Madison, WI 53704; ph 608/267-7170. 2/85

Family Physician and Internist, Pediatrician, OB/GYN, Board eligible/certified. Full or part-time, to join a busy, established group of physicians in Milwaukee. Attractive income. Send curriculum vitae to PO Box 17366, Milwaukee, WI 53217. 2-7/85

Central Iowa community desires family practice physician for office-based practice. Reply to PO Box 1475, Marshalltown, IA 50158. 2/85

Orthopedic Surgeon. An excellent opportunity is available for two orthopedic surgeons to join a progressive Medical Group in Central Minnesota. The community serves a population base of 225,000 individuals and is an excellent base for an orthopedic surgeon. St Cloud, Minnesota is the hub of the State and is home to three major colleges. It is geographically located to provide quick access to the Metropolitan-Twin Cities area. The St Cloud community has a 500-bed hospital with all the latest medical and technological advancements to assist the practicing orthopedic surgeon. If interested in this excellent opportunity, please call collect either Dr LaRue Dahlquist, President, and/or Daryl Mathews, Administrator, at 612/251-8181 and/or send curriculum vitae to St Cloud Medical Group, 1301 West St Germain Street, St Cloud, Minnesota 56301. 2-5/85

Family Practice Physician to share existing practice and fully-equipped medical office in Central Wisconsin. Salary plus incentives and opportunity for eventual purchase of practice. Excellent recreational area, a great place to live and raise a family. Send resume to Dept 552 in care of the Journal. 2/85

Excellent opportunities for Ob/Gyn's in beautiful lakefront cities in Wisconsin and Michigan. Enjoy an outstanding quality of life within an easy commute to major metropolitan areas. Reply in confidence to: Director of Physician Recruitment, Recruitment Consultants, 400 Renaissance Center, Suite 500, Detroit, Michigan 48243; ph 313/259-2000. p2/85

Family Practice Physician needed. Fremont Community Clinic, Minneapolis, Minnesota. $20 to $22 per hour, plus benefits. Part-time into full-time, some Nite-call hours. 3300 Fremont Avenue North, 55412; or call 612/588-9416; Dr R Scott Dyer, Jean, or Keta. p2-5/85

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

Wanted—Qualified physician to practice emergency medicine in southeastern Wisconsin. Our group is small and flexible. Salary is negotiable. If interested, send CV to Associated Emergency Room Physicians, SC, 1131 Sherwood Lane, Caledonia, Wis 53108; ph 414/835-4489. p1-3/85

General Internist or Family Practice physician needed to join well established solo internist/family practitioner in a beautiful lake area community of 21,000. Offering competitive salary with fringe benefits. Send CV to R C Maniquiz, MD, 600 Bay St, Chippewa Falls, Wis 54729 or call 715/723-0211. 1tfn/85

Academic Internist to join expanding dynamic young Ambulatory Care Group at the Milwaukee Regional Medical Center. Responsibilities to include: primary patient care, resident/physician education, and employee health. Opportunities for program development, administration, research, and advancement in clinical faculty track. Send inquiries to Kenneth E Smith, MD, Director, Primary Care Clinic, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Equal opportunity/affirmative action employer M/F/H. 1-3/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

PHYSICIANS EXCHANGE

continued

Internal Medicine—Board certified or eligible, to join 17-physician multispecialty clinic with 7-physician internal medicine department. Located in beautiful Wisconsin lakeshore community of 35,000. Competitive salary, complete fringe benefits, generous vacation time. Send CV to: Administrator, Manitowoc Clinic, SC, PO Box 3008, Manitowoc, WI 54220. 1-5/85

Madison, Wisconsin. Experienced physician for ambulatory care center. MedicEast, first and only independent ACC in Madison. Now well established. Located in heart of Eastside of Madison. Applicants BC/BE demonstrated experience in primary care, well-developed communication skills. Competitive salary, excellent benefits, attractive practice setting. Contact David A Goodman, MD, MedicEast, 2810 E Washington, Madison, WI 53704; ph 608/244-1213. 1tfn/85

Family Practitioner, General Surgeon, Neurologist and Pediatrician/Central Wisconsin. Excellent opportunity for Board certified/eligible physician to join 26-physician multispecialty group. 180-bed modern hospital. Plentiful recreational, cultural, and educational opportunities. Unique, attractive financial arrangements. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481; ph 715/344-4120. 1tfn/85

Family Practitioner. Rural Wisconsin community, population 3500 with service area of 8500, seeking additional family practitioner. Fifteen minutes from State Capitol with readily available tertiary medical support. Family practice department in multispecialty clinic. Excellent fringe benefits and salary. Attractive working conditions and environment. Interested parties should contact Dept 550 in care of the Journal. 12/84;1-2/85

Medical Director. Opportunity for physician with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; ph 608/251-4156. 6tfn/84

Internists—BC/BE Internist needed to join five general internists in multispecialty group practice in north-central Wisconsin. Competitive salary and benefits. General medicine training required. Cosmopolitan community and excellent recreational area. Send CV to D K Augenbaugh, MD, 2727 Plaza Dr, Wausau, WI 54401; or phone 715/847-3328. 1tfn/85

Family Practice physician MD or DO Board eligible or certified. Contact Leon Gilman, 4957 West Fond du Lac Ave, Milwaukee, Wi 53216 or call 414/871-7900. 1-3/85

Family Practice opportunities exist with several expanding Marshfield Clinic, hospital-affiliated satellites in north central Wisconsin. The Board certified/Board eligible candidate will share the philosophy of oriented care with a preventive focus, enjoy the support of over 200 physician and surgeon specialists, and live at the doorstep of year-round recreational activities. Marshfield Clinic offers an excellent salary and benefit program including a liberal vacation and education leave. Please send curriculum vitae to: John P Folz, Assistant Director, 1000 North Oak, Marshfield, Wisconsin 54449. 12/84;2/85

Pediatrician needed by Marshfield Clinic to join primary care satellite in Ladysmith, Wisconsin. Current Ladysmith staff includes five family practitioners, four internists, one general surgeon, and a radiologist. An obstetrician will be joining the group in 1985. Clinic adjoins 41-bed JCAH-accredited hospital. Rural location in beautiful northern Wisconsin. Must be Board eligible or certified. Send curriculum vitae to Dr John Ziemer, 906 College Avenue West, Ladysmith, Wisconsin 54848, or call 715/532-6651. 1-2/85

Family Practice physician needed to join five family practitioners and a general surgeon. Immediate opportunity in west central Wisconsin near La Crosse. $45,000 first year guarantee plus incentive. Excellent recreational area. Community Hospital. Send CV to: Jerrold L Kamp, Administrator, PO Box 250, Sparta, WI 54656; or phone 608/269-6731. 6tfn/84

Physicians: US Air Force Medical Corps is currently accepting applicants for physicians in the following specialties: Aerospace Medicine; Orthopedics; Ear, Nose, and Throat; Obstetrics/Gynecology; General Surgeons; Family Practitioners; Internal Medicine, and Pediatrics. For more information call: 414/258-2430. 2-4/85

Obstetrician-Gynecologist, Board certified or eligible, to join 17-physician multispecialty clinic with two physician OB/GYN department. Located in a beautiful Wisconsin lakeshore community of 35,000. Competitive salary, complete fringe benefits, generous vacation time. Send CV to: Administrator, Manitowoc Clinic, SC, PO Box 3008, Manitowoc, WI 54220. 6-12/84;1-5/85

Internal Medicine—Hospital-based private practice in small community near Eau Claire, Wisconsin. Involves critical care management. Hospital less than 20 years old, 86-bed nursing home attached. Call-sharing and guarantees provided. Affiliation with Marshfield Clinic. Two-hour drive to Minneapolis. Charles Nelson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 414/785-6500. p1-2/85

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

The Racine Medical Clinic, a progressive cluster corporation of 31 physicians is currently seeking an Obstetrician/Gynecologist physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 12tfn/84

Family Practice Oconto Falls, Wisconsin. Thirty miles northwest of Green Bay. Established practitioner needs associate to share fully-equipped clinic adjacent to 50-bed hospital. Income guaranteed by hospital. No ER call required. Abundant hunting, fishing, recreational opportunities. Contact Brett Wilson, DO, 835 S Main St, Oconto Falls, Wisconsin 54154 or call 1-800/242-4414, ext 278 or 414/846-2287. 11tfn/84

The Racine Medical Clinic, a progressive cluster corporation of 31 physicians is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 12tfn/84

Diagnostic Radiology locum tenens wanted. Responsible well-trained radiology resident available to fit your schedule including weekends and holidays. Contact PO Box 5942, Rochester, MN 55903; ph 507/284-2311 or 507/281-4956. p2/85

PHYSICIANS EXCHANGE

continued

14 MD multispecialty clinic wishes to add third OB/GYN 7/1/85. Three progressive hospitals (regional referral center for Maternal High Risk); ultrasound, office cytoscopy, colposcopy, laser, hysteroscopy, etc; no abortions. Competitive salary and benefits leading to partnership in two years. Excellent family community with multiple recreational and cultural activities available. Send CV to T E Flood, Administrator, Beaumont Clinic, Ltd, 1821 S Webster Ave, Green Bay, WI 54301. p12/84;1-3/85

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 10-12/84;1-3/85

Family Practitioners, Pediatricians, Orthopedic Surgeons, and OB/GYNs. Looking for qualified people in these areas of medicine. Located in a prosperous community in SE Wisconsin close to Milwaukee, Madison, and Chicago. I can offer pleasant surroundings, competitive salary, benefits, and fully-staffed office all within a newly decorated office. Write or call Medical Consultants, SC, 137 W Chestnut, Burlington, WI 53105; ph 414/763-3531. 12/84;1-2/85

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

Immediate opportunities for qualified physicians who possess excellent clinical and communication skills to join long-standing group of Emergency Physicians. Positions available in a popular Wisconsin area bordering Illinois. If interested, send resume to Barbara Wilczynski, Medical Emergency, Service Associates (MESA), SC, 15 S McHenry Road, Suite 2, Buffalo Grove, IL 60090 or call collect 312/459-7304. 6tfn/83

Wanted: Young Family Practitioner to join a ten-physician group in western Wisconsin. Contact R M Hammer, MD, River Falls, Wisconsin 54022; ph 612/436-8809 or 715/425-6701. 8tfn/84

Internist, with or without subspecialty, and an OB/GYN needed (Board certified or eligible) to practice in conjunction with a 7-member Internal Medicine Department and a 5-member OB/GYN Department in a 24-member multispecialty group. The Internal Medicine Department currently has subspecialties in gastroenterology, pulmonary medicine, and cardiology. The Group is located in Southeastern Wisconsin in a city of 100,000, between two major metropolitan areas of greater than one million. Estimated service area is approximately 200,000. If interested, please send CV to Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential and additional information will be sent. 7tfn/84

St Francis Medical Center—La Crosse: Full-time Family Practice faculty position with opportunity for teaching and practice in the St Francis/Mayo Family Practice Residency with Mayo Clinic faculty appointment. Currently, four full-time family physicians and 13 residents in clinic and hospital. Send inquiries to: Ted Thompson, MD, Program Director, St Francis/Mayo Family Practice Residency, 700 West Avenue South, La Crosse, Wisconsin 54601; ph 608/785-0940. 2-3/85

Family Practitioners needed to staff satellite locations and Urgent Care Centers located in Northeast Wisconsin. Please send CV to Dept 554 in care of the Journal. 2-5/85

MEDICAL FACILITIES

Family Practice for sale in Milwaukee. Ideal starter or satellite office. Excellent patient goodwill. Fully equipped and furnished three examining rooms, waiting room, and office. Approximately 900 sq ft. Contact Greg Rodenbeck, DDS, 1200 E Oklahoma Ave, Milwaukee, Wis 53207; 414/481-8111. g10tfn/84

Take over lease: EKG equipment (Phone-A-Gram) for computerized EKGs and interpretation. EKG machine, printer, and all accessories. Instant interpretation via phone line as well as tracing. Take over lease to 10-1-87 at $195 per month with unlimited EKGs or monthly payment. Call 414/367-2128 or 414/367-2120 for information. Available immediately. p2/85

Medical practice or equipment for sale in Milwaukee. Completely equipped, modern office with a modern x-ray machine. I am retiring. Please call 414/272-0250 or 414/962-9382 for an appointment. 2/85

Madison, West Side. Hilldale Professional Building. Deluxe office suites, 1200-1700 sq ft. Full service—undercover parking. Call Ralph at office 608/273-5800 or home 608/836-3586. 2tfn/85

MISCELLANEOUS

Physicians Signature Loans to $50,000. Up to 7 years to repay. Competitive fixed rate, with no points, fees, or charges of any kind. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241-6905. 10eom/83

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone: 608/263-4095 7/84;6/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

MARCH 1–3, 1985: Wisconsin Psychiatric Association at Lake Lawn Lodge, Delavan. g11-12/84;1-2/85

APRIL or MAY 1985: Wisconsin Association of Medical Directors *Annual Meeting* (in conjunction with the County Homes Association), tentatively at Stevens Point. More definite details to come. g12/84

APRIL 12–13, 1985: 8th Annual Sports Medicine Symposium. University of Wisconsin, Clinical Science Center, Madison. Sponsored by University School of Medicine, Division of Orthopedic Surgery, Section of Sports Medicine; and University of Wisconsin-Extension Continuing Medical Education. Credit: AMA Category 1, AOA Category 2-D, AAFP prescribed, University of Wisconsin-Extension CEUs. Info: Sarah Aslakson, Continuing Medical Education, Room 465B WARF, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 2/85

APRIL 17–19, 1985: *Cocaine: A Symposium.* Features nationally known speakers, including C Everett Koop, MD, US Surgeon General, and William Pollin, MD, Director, National Institute on Drug Abuse. Marriott Hotel, Milwaukee, Wisconsin. Major sponsors are Wisconsin Institute on Drug Abuse and National Institute on Drug Abuse. AMA Category I and University of Wisconsin-Extension CEUs. Contact: Sarah Aslakson, University of Wisconsin-Extension, Continuing Medical Education, Room 465B, 610 Walnut St, Madison, WI; ph 608/263-2856. 2/85

APRIL 19–20, 1985: Wisconsin Urological Society, Pfister Hotel, Milwaukee. g11tfn/84

MAY 3, 1985: Wisconsin Orthopedic Society, American Club, Kohler. g2-4/85

MAY 4, 1985: 17th Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee. "Considerations In The Diagnosis and Treatment of Lung Cancer." 8:00 am–12:00 noon. Info: Raymond C Zastrow, MD, 2400 W Villard Ave, Milwaukee, WI 53209. g2-4/85

MAY 4–7, 1985: 115th Annual Session Wisconsin Dental Association, MECCA, Milwaukee. Info: Wisconsin Dental Association, 633 West Wisconsin Ave, Milwaukee, WI 53203. g2-4/85

MAY 9–11, 1985: Wisconsin Chapter, American Academy of Pediatrics, Pioneer Inn, Oshkosh. g11tfn/84

JUNE 12–15, 1985: *37th Annual Scientific Assembly of the Wisconsin Academy of Family Physicians,* Americana Resort Hotel, Lake Geneva, Wisconsin. Info: WAFP, 850 Elm Grove Road, Elm Grove, WI 53122; ph 414/784-3656. 12/84;1-5/85

JULY 18–20, 1985: Wisconsin Society of Obstetrics & Gynecology, Olympia Resort, Oconomowoc. g2-6/85

SEPTEMBER 13–14, 1985: Wisconsin Surgical Society, Paper Valley Hotel & Conference Center, Appleton. g2-8/85

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

State Medical Society of Wisconsin
Dates and locations of ANNUAL MEETINGS 1985–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the La Crosse Convention Center.

1985—April 25–27
1986—April 17–19
1987—March 26–28
1988—April 28–30
1989—April 13–15
1990—April 26–28
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

Wisconsin Specialty Society Meetings

- Wisconsin Psychiatric Association, March 1–3, 1985, Lake Lawn Lodge, Delevan
- Wisconsin Urological Society, April 19–20, 1985, Pfister Hotel, Milwaukee
- Wisconsin Chapter: American Academy of Pediatrics, May 9–11, 1985, Pioneer Inn, Oshkosh
- Wisconsin Academy of Family Physicians, June 12–15, 1985, Americana Resort, Lake Geneva

* * *

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 25–27, 1985, La Crosse

- Wisconsin Society of Anesthesiologists
- Wisconsin Dermatological Society
- Wisconsin Chapter, American College of Emergency Physicians
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Internal Medicine
- Wisconsin Academy of Ophthalmology
- Wisconsin Otolaryngological Society
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine & Rehabilitation
- Wisconsin Society of Plastic Surgeons
- Wisconsin Society for Preventive Medicine
- Wisconsin Society of Radiation Oncologists
- Wisconsin Surgical Society

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

SEPTEMBER 13–15, 1985: Wisconsin Society of Anesthesiologists, American Club, Kohler. g2-8/85

OTHERS

MARCH 1–3, 1985 (Illinois): *Midwest Clinical Conference,* sponsored by Chicago Medical Society, at Westin Hotel, Chicago. Info: Chicago Medical Society, 515 North Dearborn St, Chicago, Ill 60610; ph 312/670-2550. gl-2/85

MARCH 20, 1985 (Illinois): *Trends in Specialization: Tomorrow's Medicine,* at Westin Hotel O'Hare, Chicago. Jointly sponsored by the American Board of Medical Specialties and the Royal College of Physicians and Surgeons of Canada. Info: American Board of Medical Specialties, One American Plaza, Suite 805, Evanston, IL 60201; phone 312/491-9091. g12/84;1-2/85

APRIL 10–14, 1985 (Florida): *20th Annual Clinical Conference* at Longboat Key Club, Longboat Key. Sponsored by the Marquette-MCW Medical Alumni Association and the Medical College of Wisconsin. Info: Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226; ph 414/257-8367. 1-3/85

JUNE 5–8, 1985 (Alaska): Alaska State Medical Association Annual Convention in Haines. Info: Alaska State Medical Association, 4107 Laurel St, Ste #1, Anchorage, Alaska 99508; ph 907/562-2662. g2-5/85

AUGUST 1–4, 1985 (Georgia): *International Doctors in Alcoholics Anonymous Annual Meeting.* Hyatt Regency Hotel, Savannah. Reservations may be made at a later date when specific details and instructions are published. For further information contact: Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44511; ph 216/782-6216. g12tfn/84

SEPTEMBER 17–18, 1985 (Illinois): *Medical Practice and Hospital Privileges,* at Chicago Marriott O'Hare, Chicago. Info: American Board of Medical Specialties, One American Plaza, Suite 805, Evanston, IL 60201; phone 312/491-9091. g12/84;1-8/85

AMA

JUNE 16–20, 1985: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 8–11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

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Lilly & Co, Eli 24
Ceclor®
Marion Laboratories, Inc 75, 76
Cardizem®
Medical Protective Company 10
Navy Medical Programs 39
Offerman & Co, Inc 48
PBBS Equipment 68
Professionals Insurance Company, The 4
Roche Laboratories . . . . . 85, BC
Dalmane®
S&L Signal Company 74
United States Army Air Force 49
United States Army Reserve 74
Upjohn Company, The 55
Motrin®
Winthrop Company, The 73, 74
Talwin® Nx
WISPAC . . . . . 72 ■

DIAGNOSIS & TREATMENT OF COMMON HUMAN TUMORS

Presented by American Cancer Society—Kentucky Division

April 10–13, 1985/Lexington Marriott Resort, Griffin Gate Lexington, Kentucky

Info: John R van Nagell Jr, MD, University of Kentucky Medical Center Lexington, KY 40536 g2-3/85

THE LA CROSSE EXERCISE PROGRAM PRESENTS ITS 1985 WORKSHOP SCHEDULE

University of Wisconsin-La Crosse La Crosse Lutheran Hospital/Gundersen Clinic

Cardiac Rehabilitation: Apr 15-19; June 10-14; July 15-19; Nov 18-22

Teaching Stress Management and Relaxation Skills; June 2-7; July 14-19; Nov 10-15

Development of Corporate & Industrial Wellness Programs by Health Care Providers: June 10-13

Fitness and Weight Control: Mar 25-29; June 3-7; July 22-26

Info: Philip K Wilson, La Crosse Exercise Program, University of Wisconsin-La Crosse, La Crosse, WI 54601; tel 608/785-8686 2/85

International Childbirth Education Association

to host 1985 Conference

in cooperation with Methodist Hospital who will coordinate the local planning committee.

in Madison, June 20–23

at the Sheraton Inn and Conference Center

The four-day conference is expected to draw 400 to 500 persons from across the nation, including childbirth educators, nurses, physicians, parent advocates, and others interested in the current changes in pregnancy, birthing, and early parenting.

Persons interested in assisting with the conference or learning more details can call Methodist Hospital, Madison, at 608/258-3290.

NEWS YOU CAN USE

MORE PHYSICIANS LEANING TOWARDS ADVERTISING. Radio, television advertising of physicians' fees is an issue that generates strong reactions and differing opinions within the profession, according to the AMA Dept of Survey and Opinion Research. The percentage of pro-advertising physicians more than doubled between 1978 and 1983, from 8% to 17%. The overwhelming proportion of physicians, however, continued to disapprove of listing fees. Younger physicians were more than twice as likely as older physicians to approve of fee advertising.■

WISCONSIN RANKS #17 IN MEDICARE SIGN-UP RATE. Nearly 35% of Wisconsin physicians elected to become "participating" physicians under Medicare, according to data recently compiled by the Federal Health Care Financing Administration. HCFA reports that 2,802 physicians (MDs and DOs) in Wisconsin have signed agreements giving Wisconsin the rank of 17 in nationwide Medicare participation. Alabama is ranked first in MD participation with 53.9% and South Dakota is ranked last or #51 with 5.6% of its physicians participating. Other states in the North-Central region and their participation rank and percentage are: Illinois: #30—23.5%; Iowa: 14th—35.9%; Michigan: #9—43.4%; Minnesota: #43—18.0%; and North Dakota: #49—10.4%■

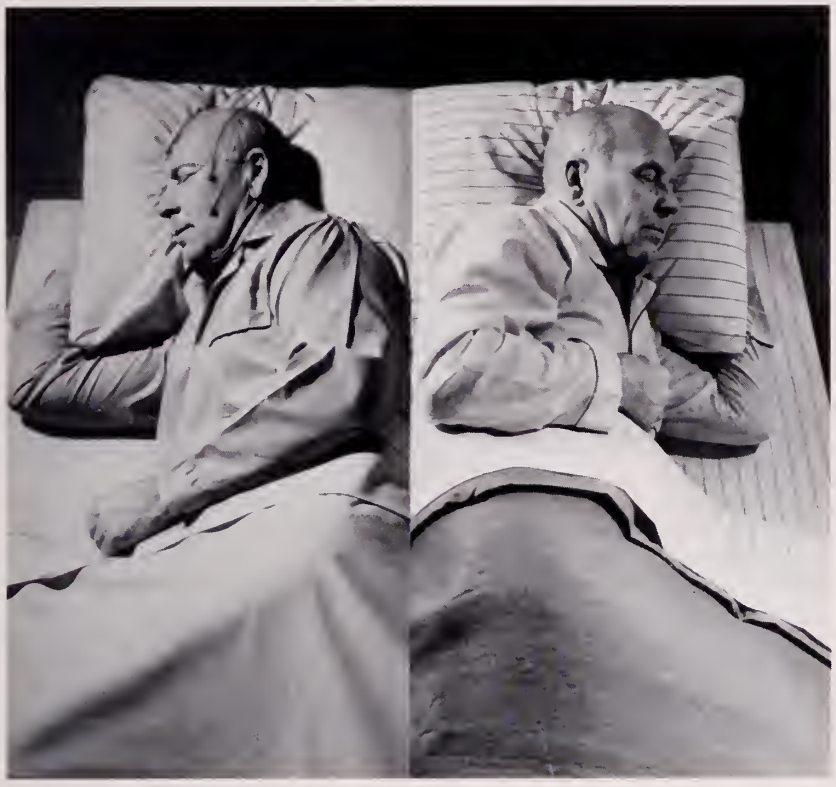
PHYSICIANS TO RECEIVE 3% INCREASE IN MEDICAID REIMBURSEMENT. Physicians will receive an overall 3% increase in the maximum allowable reimbursement paid by the Wisconsin Medical Assistance Program (WMAP) for services rendered on or after January 1, 1985, the Bureau of Health Care Financing has announced. For each covered service billed to the WMAP, the physician provider will be reimbursed the lesser of the physician's usual and customary charge or the updated maximum allowable fee for the service. Physicians may obtain copies of the updated maximum allowable fee schedule by writing: Records Custodian, Bureau of Health Care Financing, Wisconsin Division of Health, PO Box 309, Madison, WI 53701.■

CHAMPUS APPOINTS NEW PROVIDER FIELD REP FOR WISCONSIN. CHAMPUS has named Pat Wisniewski as the new field representative to serve physician providers in the Wisconsin and Upper Michigan Peninsula. She is available for handling problem situations, workshops, policy issues or on-site visits. She can be reached by writing: Pat Wisniewski, PO Box 216, Greendale, WI 53219, or calling 1-414-423-0902. Physician providers should *not* refer her name to CHAMPUS beneficiaries. They should be referred to a Health Benefit Advisor. A list of Wisconsin Health Benefit Advisors is available through Ms Wisniewski's office at the above address.

CHAMPUS/CHAMPVA claims should be submitted to CHAMPUS/CHAMPVA, RI Blue Cross and Blue Shield, PO Box 1714, Providence, RI 02901-1714. Claims inquiries can be directed to the same address or by calling toll-free at 1-800-622-3131 or 1-401-272-8500, extension 2546, 2547 or 2560.■

CANCER SOCIETY LAUNCHES EDUCATION CAMPAIGN ON COLORECTAL CANCER. The American Cancer Society—Wisconsin Division has announced that it is beginning a public and professional education and awareness campaign on colorectal cancer. Physicians should be aware of the campaign known as "Colorectal Health Check" and be prepared for increased requests from patients for information on the tests for colorectal cancer. The colorectal cancer awareness program is part of a major American Cancer Society three-year accelerated nationwide campaign to reduce America's death toll from colorectal cancer. The campaign will attempt to expand the use of the three standard diagnostic techniques for the early detection of colorectal cancer in asymptomatic patients: the digital rectal examination, the stool blood test, and proctosigmoidoscopy. As part of the campaign, the Cancer Society will be distributing 3″×5″ cards telling persons, particularly those 50 years and over, to ask their physicians about colorectal cancer detection tests. For further information contact the ACS-Wisconsin Division at 611 North Sherman Avenue, Madison, WI 53704.■

COMPLETE LABORATORY DOCUMENTATION[1-5] ... EXTENSIVE CLINICAL PROOF



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References: 1. Kales J *et al: Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther* 19:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology* 26:121-137, 1983.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

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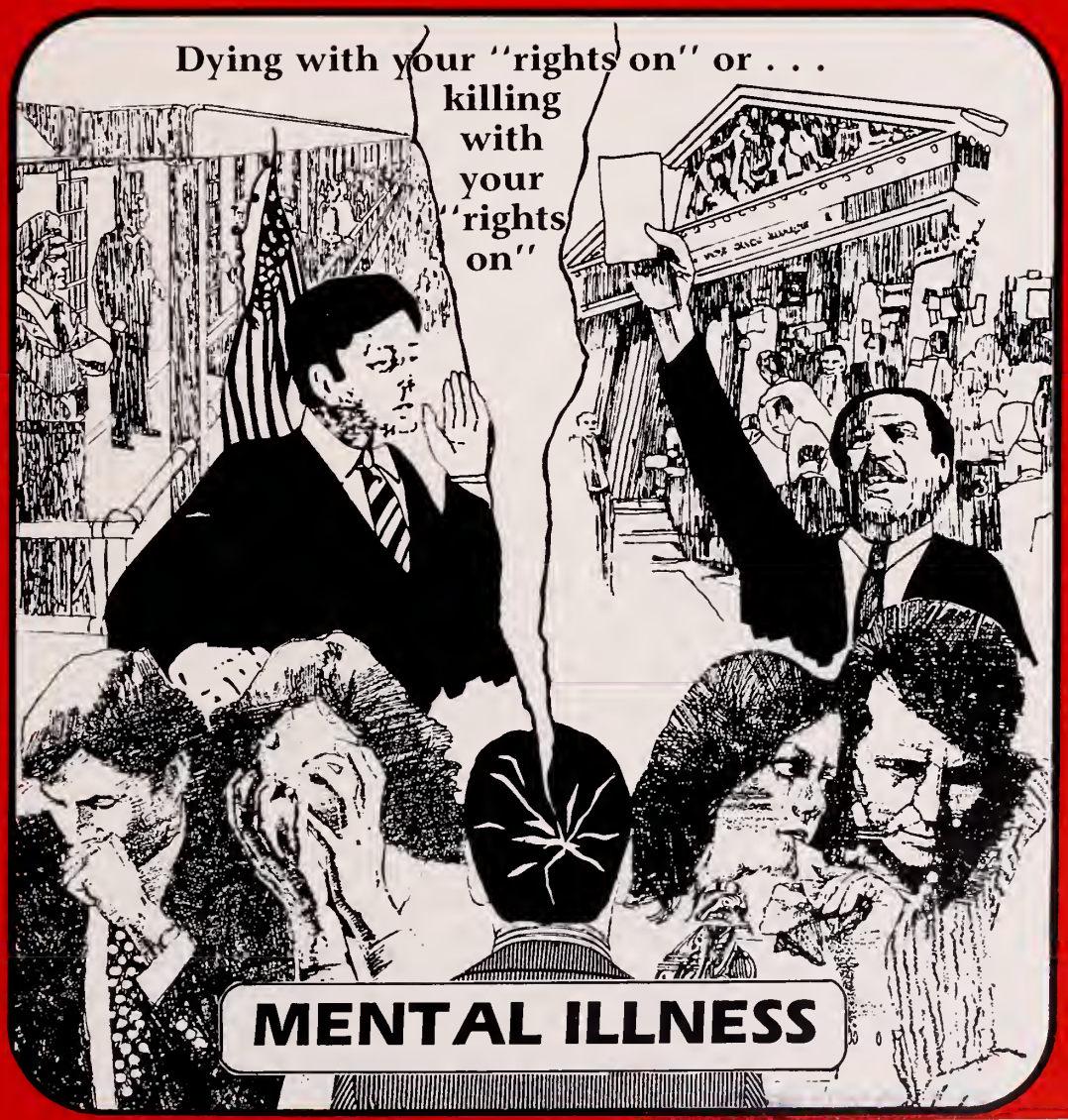
WISCONSIN MEDICAL JOURNAL

Official Publication of the State Medical Society of Wisconsin



See page 6

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COLLEGE OF PHYSICIANS OF PHILADELPHIA
APR 1 - 1985

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CONTENTS

March 1985

SPECIAL FEATURES

President's Page

5 Welcome to Wisconsin regulation
Timothy T Flaherty, MD
Neenah

Editorials

6 Dying with your "rights on" or . . . killing with your "rights on"
Richard D Sautter, MD
Marshfield

7 Appropriate disposition

7 Product liability laws

8 Doctors' draft

8 Futility

9 Fresh frozen plasma

9 $2,500 per day
Victor S Falk, MD
Edgerton

Letters

10 Medical staffs and peer review
S E Sivertson, MD
Madison

10 Work-related injuries
Steve Hargarten, MD
Milwaukee

11 William H Studley, MD: 1903–1985
George E Moore, MD
Ashland, Illinois

Special

13 Child abuse—After the report is made

16 Magnetic resonance imaging (MRI): View of the Wisconsin Radiological Society
Roland A Locher, MD
La Crosse

17 Suggested patient form for obtaining DES-exposure information

18 Pediatricians establish policy statement for alcohol abuse education in school

Socioeconomics

49 Governor delivers 1985–87 budget; many healthcare items included

1983 Health spending

News you can use

64 Recent changes in Medicare regarding durable medical equipment

Practice management study courses offered

Physician fee increases slow

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84, No. 3

CONTENTS

STATE MEDICAL SOCIETY OF WISCONSIN

SCIENTIFIC MEDICINE

23 Endemic Kawasaki disease in rural Wisconsin
Thomas M Sutton, MD
Bradley Sullivan, MD
Marshfield

25 Technetium^{99m}-pyrophosphate scintigraphy in amyloid cardiomyopathy
Michael J Ptacin, MD
Virinderjit Bamrah, MD
Edmund Duthie, MD
Wood

28 Legal aspects of medical genetics in Wisconsin
Ellen Wright Clayton, JD
Madison

COVER DESIGN by KC Graphics, Inc, Madison, depicting the plight of individuals in need of institutional care and who, because of mental illness, drug addiction, or alcoholism are unable to accept such care voluntarily. The courts give them the right to remain "free" until "dangerousness" is proved, usually when a crime has been committed or an unfortunate death occurs. Legislators, at the urging of involved families, professionals, and social agencies, will soon be introducing legislation that will make it easier for individuals needing psychiatric care to be involuntarily committed.

33 Physician morbidity: a limited study
Jeffrey Larson, MD
Betty Joan Maly, MD
Joanna Spiro, EdD
Milwaukee

ORGANIZATIONAL

39 SMS Board reaffirms its position: Don't drop CME requirement

40 Mark your calendar for SMS Annual Meeting April 25-27 in La Crosse

Medical Society asks broadcasters to help fight alcohol abuse

41 SMS Task Force on Medical Care to meet March 22

42 State Medical Society of Wisconsin Program Schedule—Annual Meeting Apr 25-26-27, 1985, La Crosse

44 House of Delegates: 1985 State Medical Society of Wisconsin (list of delegates and alternates by district and sections)

46 SMS dues due by May 15

DEPARTMENTS

46 COUNTY SOCIETIES: Dane . . . Sheboygan . . . Brown

59 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Miscellaneous . . . Announcements . . . Advertisers . . . Medical meetings—continuing medical education ■

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THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5600 member physicians in Wisconsin, comprising 55 county medical societies and 25 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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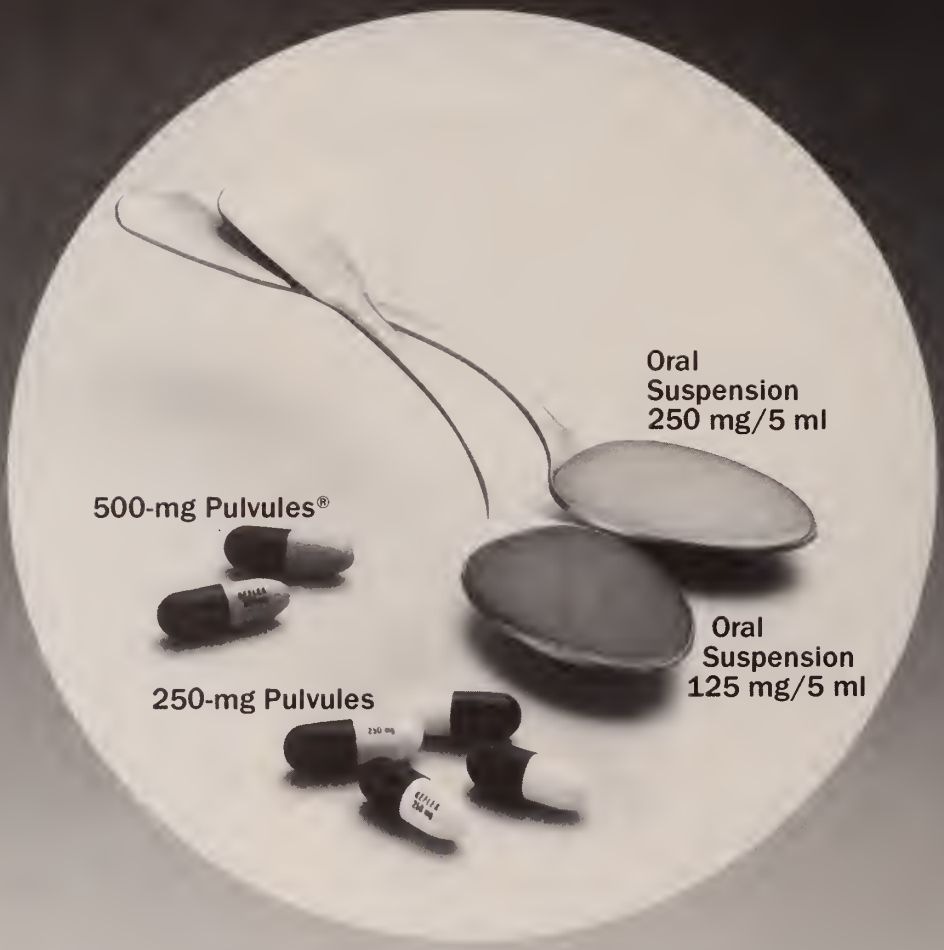

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Timothy T Flaherty, MD

Welcome to Wisconsin Regulation

THAT MAY NOT be the wording of the sign at our state borders; however, that is the message that has been, and is continuing to be, received by the citizens of Wisconsin involved in health care; please see the Report of the Wisconsin Radiological Society's Committee on Magnetic Resonance Imaging (MRI) appearing in this issue on page 16.

When the chairman of Wisconsin's largest corporation (Kimberly Clark) initially announced his concern about continued corporate residency in Wisconsin, he enumerated three areas which *he* perceived as negative factors: (1) Wisconsin's high level of taxation. (2) Wisconsin's state bureaucracy (the Regulators). (3) The high cost of medical care in the Fox Valley.

On May 30, 1984 I attended the dedication of the General Electric Medical Systems, Magnetic Resonance Center, (MRI) a new 216,000 sq ft MRI plant representing an expenditure of $25,000,000 by GE in Wisconsin. Governor Anthony S Earl delivered the dedication address and took personal pride and "credit" for the expansion of GE Medical Systems in Wisconsin. During that same time interval, a special law was passed and signed by Governor Earl allowing the Medical College of Wisconsin–Milwaukee, and the University of Wisconsin–Madison, to be exempted from the Certificate-of-Need (CON) process and from the $1,000,000 capital expenditure moratorium established by the Department of Health and Social Services (DHSS). As you will read in the report of the Wisconsin Radiological Society, the State (DHSS) has now taken the position of *not accepting* letters of intent for MRI scanners until February 1986. Unbelievably, the State Regulators (DHSS) have refused to accept CON applications (now called Capital Expenditure Review—CER) from the two University facilities that have operational scanners. This stance denies the University Medical Centers the opportunity to receive the approval necessary to capitalize the expense of these MRI scanners.

Are the State Regulators (DHSS) against advances in medical technology?

Evaluating the recent performance of the State Regulators regarding the distribution of CT scanners throughout Wisconsin the answer to that question by many would be "YES." The State Regulators through the CON process denied a number of hospitals the authority to obtain CT scanners. Physicians in many of these hospitals believed this denial restricted their ability to deliver high quality medical care and thus many of these denials were appealed through the legal process. To my knowledge, the applicants won all of the appeals and the State Regulators lost without exception. The legal expense of waging such a battle against the resources of the State Regulators consistently cost the hospitals between $100,000 and $200,000. For one Fox Valley Hospital, the legal costs of fighting the denial through the "system" exceeded the cost of purchasing the CT scanner. The Kimberly Clark Chairman certainly would be correct in characterizing this expense as an excessive health care cost. Additionally, we do not have an accounting, nor is the State very accountable, for its share of the legal and administrative costs of the battle to halt the acquisition of this state-of-the-art imaging modality.

SMS has consistently recommended elimination of the CON (CER) process. However, the determination to retain CER review authority in DHSS or logically shift this to the new Mandatory Hospital Rate Review Commission is the skirmish now being fought in the Madison bureaucracy.

Brandeis Dean Stewart Altman, PhD, who is chairman of Medicare's Prospective Payment Assessment Commission, lists three qualifications of a regulator: (1) The regulator should be under 40 years of age and in good health, (2) should know nothing about the industry that he will regulate, and (3) must be inconsistent and able to change rules rapidly.

I have been attending farewell events with Fox Valley friends of employees of Kimberly Clark Corporation who are moving to the new Corporate Headquarters in Dallas. Texas has no personal income tax, a business-friendly State Government, and has a "sunset provision" on its Health Facilities Review (CON) that will expire this year.

Justice John Marshall said many years ago, "The power to tax is the power to destroy." Wisconsin Regulation has demonstrated its power to control, to prop-up, to disturb, and potentially to destroy. ■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

Dying with your "rights on" or . . . killing with your "rights on"

IN 1972 THE FEDERAL district court declared Wisconsin's civil commitment procedure statutes unconstitutional (Lessard *vs* Schmidt, ED, Wisconsin 1972, 349F Supp. 1098.)

In the name of fundamental liberties, involuntary commitment was virtually eliminated. What has followed has been an unspeakable suffering of families with persons in need of institutional care and who, because of mental illness, drug addiction, or alcoholism are unable to accept such care voluntarily. There are families who could do nothing to help family members known to be dangerous to others. (The tragedy in Onalaska may be a recent example.)

This is a pernicious law administered in a perverse manner.

I have had personal experience with this procedure and with the courts. I have found the court to be primarily concerned with the letter of the law, procedure, protocol, and so forth, with not a particle of empathy, or more importantly, a halfpenny's worth of common sense. The court was greatly concerned, to a pious fault, that my son's rights be protected at all costs, his life included. As I stood at the hearing, it occurred to me that ***no*** one could possibly be as interested in my son's welfare as I, which I suspect is a common and familiar feeling for family members at such hearings. It was the "case" that was being considered; not a sixteen-year-old's welfare but the "case" to be settled by prescribed procedure, 51.15, 51.70, 51.45. Had my son declined voluntary commitment he would in all likelihood not now be in college but severely physically ill and perhaps worse. We were very fortunate.

I grieve for the parents who fought to have their child or family member receive treatment, knowing them to be suicidal or homicidal, and having the fact ultimately proved.

I know the feeling of total helplessness described by many parents realizing their family member required help, apparent even to those with questionable mental competency. I, as others, went to the courts seeking help. What I received was a crude lesson in the vagaries and inhumanity of the law and an exposure to a cold contempt for an individual's welfare to say nothing of the welfare of others. I was hard pressed to imagine any citizen being treated so poorly. No crime was committed; no one suffered tangible loss. Where was the compassion, the so-called mercy of the court? It is very hard to have respect for such a system. The fault may not be entirely with the system but also with the players; but more likely both.

I wonder if the courts feel a twinge of conscience following a suicide or murder; after all the letter of the law was fulfilled. They are unable or don't wish to recognize that in protecting an individual's civil liberties they may be denying them the right to appropriate treatment, and at times sentencing them, or others, to death. If a problem is recognized by the courts, why then have they not initiated change? It is their system.

Somewhere it is written "the law should serve the people." This concept was obviously thrown aside regarding Wisconsin's commitment procedure, both as it applies to individuals and the public. What group or individual does this law serve? Only the practitioners of the law? Change should not be delayed.

Medicine serves the individual, and though our profession may not be lily-white in all areas in this regard, the legal system on this issue would be hard pressed to become even charcoal in color. It behooves us as physicians to help initiate change in the statutes to protect the individual, his family, and other persons from a capricious, pernicious law and its servants.

—Richard D Sautter, MD, Marshfield

Editor's note: *State Senators Brian Rude, Coon Valley, and Susan Engeleiter, Menomonee Falls, and Representative John Medinger, La Crosse, (at the State Medical Society's request) will soon be introducing legislation that will make it easier for individuals needing psychiatric care to be involuntarily committed.*

Their bills propose a new standard for civil commitment to be placed on the statutes. This standard would require a determination that "unless the individual receives immediate treatment, he or she will suffer substantial mental deterioration or develop irreversible chronic mental illness or that the individual is unable to make an informed decision because of a mental condition." "Dangerousness" would not have to be proved.

The legislators hope, as does the Society's Mental Health Committee, that the proposal would help reduce the needless suffering by getting these people off the street and into psychiatric treatment.

The legislators are to be commended for introducing this enlightened legislation.

—Victor S Falk, MD, Edgerton

Editorial Board comment: *This is a beautifully written editorial and so very true. Another Board member's son was not so lucky as was the author's, and now spends his time in a state of paranoid terror. But the law says his freedom is his paramount interest, but freedom to do what?—to wander up and down State Street (Madison), sleep in empty buildings and in churches, and hit the soup lines? For him it is a terribly painful and unending affliction. Yet, our laws insist no one can do anything for him until he hurts himself or someone else, because it is his inalienable legal "right" to be free if he chooses. But unfortunately the law doesn't realize it is not the son who is making this decision—it is mental illness. What a tragedy and what a waste, and unfortunately there are many, many more just like him. We were brought up and taught that we are a country where the people rule, not the courts or the lawyers—where does it divide the rights of one* vs *the rights of another—currently it (the law) does not.*

Appropriate disposition

HHS SECRETARY Heckler has proposed that the federal excise tax on cigarettes be extended to shore up Medicare. The 16¢ a pack is scheduled to drop to 8¢ on October 1. If renewed at the current level, the tax would generate $1.7 billion a year. Secretary Heckler has proposed that this be earmarked for the Medicare trust fund. The AMA supports increasing the excise tax, and agrees that revenues should be earmarked for Medicare.

It certainly is appropriate that the funds generated from the tax on cigarettes should go to Medicare. Certainly tremendous amounts of Medicare funds are expended on those unfortunate but misguided individuals who have been cigarette smokers and subsequently developed emphysema, lung cancer, and/or other tobacco-related illnesses. It would be difficult to estimate the extent to which the care of these respiratory cripples drains the Medicare fund, but Secretary Heckler certainly has the right idea.

—*Victor S Falk, MD,* Edgerton

Product liability laws

SENATOR ROBERT W KASTEN, Jr of Wisconsin, along with 28 cosponsors, has introduced legislation to clarify the product liability laws. Sidney Shindell, MD, LLB, Professor and Chairman of the Department of Preventive Medicine at the Medical College of Wisconsin, Milwaukee, wrote in the November/December 1984 issue of the *American Council on Science and Health News and Views* on the subject.

Doctor Shindell pointed out that the question of product liability depends on where the injury occurs. This is true because of the idiosyncrasies of state laws and the fact that there is little agreement among states on these issues.

The sponsors of the bill (S-44, 98th Congress) have attempted to bring order out of this confusing state of affairs by proposing uniform national standards for product liability. Naturally there are two schools of thought about the proposed legislation. The proponents of the bill are organized into two major coalitions, the Products Liability Alliance (189 corporations and trade associations) and the Coalition for Uniform Product Liability Law (252 corporations and trade associations). These include the Chamber of Commerce, National Association of Manufacturers, National Federation of Independent Businesses, American Insurance Association, Alliance of American Insurers, and the American Legislative Exchange Council. As might be expected, those opposed to the bill include the American Trial Lawyers Association and Public Citizen's Congress Watch, as well as other labor and consumer groups.

The new law would provide one uniform definition of liability for the multitude of definitions that now exist. Liability would result if:

- . . . a product is unreasonably dangerous in construction or design, or
- . . . there is a failure to provide adequate warnings or instruction, or
- . . . the product does not conform to an express warranty, and
- . . . the unreasonably dangerous aspect of the product causes harm.

Studies indicate that under the current situation more money goes into the pockets of lawyers and expert witnesses than eventually gets to the claimants.

Doctor Shindell concludes that the approach of the Kasten bill is the compromise that many have been searching for: to bring order out of the present chaos, to give manufacturers and suppliers reasonable guidelines, and to give consumers reasonable protection.

This appears to be a reasonable approach to a complicated problem, and deserves the support of the medical profession.

—*Victor S Falk, MD,* Edgerton

Editorial Board comment: *Several years ago when physicians were unable to purchase medical malpractice insurance, limits on liability for medical malpractice were opposed by some Wisconsin business men because limited liability for physicians established a "special class" favoring physicians while manufacturers had no such protection. Manufacturers now feel the heat of heavy and sometimes unwarranted awards and they scurry for the umbrella of legal protection. We agree that the medical profession should support legislation in the area of product liability, but Senator Kasten and others should be reminded that order needs to be brought out of the chaos of the medical malpractice situation as well.*

Doctors' draft

YOU MAY RECALL that a couple years ago I wrote an editorial inspired by a release from the Department of Defense and published in the *American Medical News*. It reported at that time that there were only enough medical personnel in the armed services to care for one out of ten military casualties in the event of a national emergency. This inspired hundreds of older doctors to offer their services to the military in the event of a national emergency and to be available on 24-hour notice. However, the military was not interested in these old fuds or retreads. Conversely, younger physicians were not interested in the military.

On January 12 of this year an editorial appeared in the *Chicago Tribune*. It was entitled "Untended American Wounded." It pointed out the shortage of qualified medical personnel in the military and used exactly the same figures stating that the shortage was so severe that only one in ten wounded in any major conventional war would receive life-saving treatment. The *Tribune* editorial writer concluded that Congress should grant what the report urgently requested, a rewriting of the law to permit the immediate drafting of needed medical personnel and that this was national security at its most essential. The armed forces need at least 60,000 additional doctors and nurses and other medical specialists if the government is to comply with the Selective Service Act.

This sounds rather drastic, but it has happened before. Many physicians who had served for years during World War II were quite shocked when a special doctors' draft was enacted in the early 1950s. It was especially distressing for physicians who had served slightly less than 24 months in World War II and were recalled to active duty for another two years.

An Associated Press release which came out at the same time as the *Tribune* editorial reported on an NBC news program. The NBC news reported that numerous cases of questionable medical practices, including some that involved death of the patients, have been found in all of the military services. NBC said a confidential report by the Navy "details how previous efforts to improve medical care have failed at all six Navy hospitals investigated."

It appears that doctors' draft, although undoubtedly unpalatable to young physicians, may become necessary to not only improve the quantity but also the quality of medical care for the armed services.

The image of medicine as a profession is already somewhat scruffy in some eyes. Editorials and press releases like these are not polishing that image. There seem to be three alternative solutions: younger physicians must plan to spend some time in service; or the services must learn to accept older physicians who are available because of retirement of their own volition or by virtue of mandatory retirement requirements within their groups; or another doctors' draft!

—*Victor S Falk, MD,* Edgerton

Futility

ALTHOUGH IT IS contrary to the policy of the *Wisconsin Medical Journal* to reprint material that has been published elsewhere, the following comments deserve to be more widely disseminated.

Dr C Rollins Hanlon, who is director of the American College of Surgeons, wrote in the January issue of the *Bulletin of the American College of Surgeons*. He first described advances in surgery and technology and the wave of editorial effusion that resulted after the baboon-heart transplant and the two mechanical hearts. He then went on to say, "Scientific developments that foster such surgical attempts are akin to the technology that allows a plaintiff's lawyer to fly halfway around the world to establish his representation for victims of an industrial disaster and to enter the nation's living rooms on television soon thereafter. Here one may see a bland defense of the contingent fee even in the face of hostile inquisition by television personalities skilled in the art of electronic karate. Answers to whether the Bhopal catastrophe will result in fair compensation for the Indian victims of this stunning tragedy may be looked for in the record of personal injury litigation in the United States. It has clearly benefited US lawyers enormously, and small numbers of patients or their relatives have also profited financially. But there is little evidence that mammoth awards do much more than increase the costs and hazards of medical practice."

Doctor Hanlon also expressed concern similar to that noted in an earlier editorial by Dr Wayne Boulanger. "On a similar note of futility, when state Professional Review Organizations absurdly dictate a specified percentage goal for reduction in complications after cholecystectomy, it seems unlikely that such regulation and threats will bring about a higher standard of practice than the medical profession has been able to achieve by pride of performance and the ingrained desire of physicians to provide for their individual patients the best possible care."

Doctor Hanlon expresses very well his thoughts and the concerns of many of us.

—*Victor S Falk, MD,* Edgerton

Fresh frozen plasma

THE NATIONAL Institutes of Health hold periodic conferences on a variety of subjects and publish a consensus statement at the end of each. A recent conference was devoted to the use of fresh frozen plasma.

The conference statement concluded that the administration of fresh frozen plasma has increased dramatically in recent years despite the paucity of definitive indications for its use. This increase has occurred in the presence of mounting evidence of its potential risks, which include viral hepatitis and possibly AIDS. Many patients who receive fresh frozen plasma can be managed more effectively and safely with alternative modalities.

Fresh frozen plasma is indicated for some documented coagulation protein deficiencies as well as for selected patients who require massive transfusions. It is indicated for patients with multiple coagulation defects as in liver disease, in conjunction with therapeutic plasma exchange for thrombotic thrombocytopenic purpura, for infants with protein-losing enteropathy, and for selected patients with other immune deficiencies.

Its use in most other cases should be discouraged. There is no justification for the use of fresh frozen plasma as a volume expander or as a nutritional source.

Figures from Wisconsin blood banks indicate that utilization of fresh frozen plasma has increased far beyond all reasonable indications. Apparently this utilization is going through a phase comparable to the former use of a single unit of whole blood or a series of vitamin B-12 injections simply as a "tonic."

—*Victor S Falk, MD,* Edgerton

$2,500 per day

A FORMER WISCONSIN physician has retired to Florida. Recently he stuck the tip of his finger with a catfish spine. Although in his own opinion it was not necessary, he was hospitalized for two days. His bill was $5,000!

Small wonder that there are complaints about the high cost of medical care.

—*Victor S Falk, MD,* Edgerton

Editorial Board comment: *Usual and customary charges!!? Was he insured? DRGs anyone?* ■

PSYCHIATRIST
psy·chi·a·trist
(sī-kī′-ə-trĭst, sī)

psy·chi·a·trist (sī-kī′ə-trĭst, sī) n. A physician specially trained to practice psychiatry. psy·chi·a·try (sī-kī′ə-trē) n. The study, diagnosis, treatment, and prevention of mental illness. [psych(o)- + -IATRY.] —psy′chi·at′ri·cal adj. —psy′chi·at′ri·cal·ly adv.

Psychiatrist. Look it up in a dictionary and you will likely find definitions that speak of a doctor whose practice pertains to working with patients afflicted with mental, emotional, and behavioral disorders. And that's true . . . as far as it goes.

At Milwaukee's St. Mary's Hill Hospital, we believe some elaboration is necessary . . .

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Medical staffs and peer review

Editor's Note: *In mid-November S E Sivertson, MD, Madison, made a presentation on peer review before the Divine Savior Hospital Medical Staff, Portage. Later this correspondence developed. It may be useful to all medical staffs concerned with peer review.*

TO JOSEPH PAVELSEK, MD, Portage: After my presentation on peer review one of those in attendance pointed out—and rightly so—that I did not offer positive things physicians could do. Upon returning home, I thought about this and summarized some comments which were sprinkled throughout the discussion.

The recommendations I would make at this time are:

1. Each physician should thoroughly learn the *claim form* and how it is used.

2. Each physician should thoroughly learn the language used on the claim form; *ie,* the International Classification of Diseases (ICD-9) and how it has been adapted into DRGs.

3. Discharge diagnoses should be complete, with the proper language of DRGs.

4. Each physician should learn the system now employed and follow its evolution, including the definitions; *ie,* for primary diagnosis, elective procedure, etc.

5. The hospital could develop its own ongoing peer review system modeled after the PSRO technique (which is currently used by nongovernmental third party payers).

6. Once knowledgeable about the system physicians should be better prepared to identify inherent weaknesses in it and act accordingly.

7. Physicians should work closely with components of the State Medical Society to assist in lobbying.

8. A peer review cost analysis system with the county medical society and/or hospital should be looked at; *ie,* average cost and acceptable range for procedure or other type of service. (County boards are among those also interested.)

9. At regular intervals the hospital should provide an anonymous copy of a patient's bill to each of its medical staff.

From the standpoint of these data lending themselves to objectives for continuing medical education, let me suggest the following:

1. When inviting guest speakers, send them your outcome data in advance so that they can relate the presentation to it.

2. Another variation of this is to schedule the guest lecturer's presentation after the guest sits in on an outcome data review session by the committee.

Until something better comes along, this must suffice. I can assure you, however, that many of the things listed above have been and are being implemented at the University Hospital.

—S E Sivertson, MD
Assistant Dean for Student
and Clinical Affairs
University of Wisconsin-Madison
Medical School
1300 University Avenue
Madison, Wisconsin 53706

Work-related injuries

TO THE EDITOR: In a recent editorial entitled, "The cost of work accidents," in the December 1984 issue of the *Wisconsin Medical Journal,* physicians were enlightened about the high cost of work-related injuries. In addition, an interesting paragraph of the editorial showed how a $500 work injury offsets the profits of a company making bread or packing meats.

My problem with the editorial was how it ended—on a note of finger-waving, parental cautioning. Be careful of the malingerer!! "Fudging is both unethical and unconscionably costly"—so ends the editorial and so begins the formation of attitudes towards patients who are injured while at work.

The problem of work-related fatal and disabling injuries in the United States is immense, as the editorial points out. The challenge to prevent or ameliorate the injuries is tremendous—a point omitted in the editorial. The problems of rehabilitation and getting the employee back to work are real and demand forthright attention. But what about the 11,200 fatalities in 1982? And what about the fact that the highest death rate among agricultural workers is in the 5-14 year age group!! The problem of work-related injuries, including rehabilitation, needs the unbiased involvement of physicians, not further views on the behavior of some workers.

To be blunt: I call upon the physicians in this state to reduce the toll of work-related injuries by working with the employer and the employee in identifying strategies for injury control. Failure to tell your patients to wear seat belts is simply unconscionable.

—Steve Hargarten, MD, MPH
Emergency Department
St Joseph's Hospital
5000 West Chambers St
Milwaukee, Wisconsin 53210

William H Studley, MD: 1903–1985

To the Editor: Dr William H Studley was perhaps Wisconsin's most influential and well-known psychiatrist of the post World War II period. Because of his considerable psychiatric accomplishments and leadership, his demise is of particular interest to the profession of our state.

I was asked to eulogize Doctor Studley during his memorial service at the St Paul's Episcopal Church in Milwaukee and did so on February 8. A copy of the oration is enclosed for consideration in publishing in the *Wisconsin Medical Journal.*

Editor's note: *Although we generally refrain from publishing eulogies (mostly because of other space commitments), there are occasions when we take exception such as this one. Therefore, we are pleased to publish Doctor Moore's eulogy.*

The quiet passing of Dr William H Studley on the third day of February (1985) marked the close of one of Milwaukee's most distinguished and colorful medical careers. For me, it was also the terrestrial conclusion of a sterling friendship of nearly 40 years. It is a large company of friends, family, professional associates, former patients, and community now realizing a loss for which there is no replacement.

Doctor Studley's charismatic presence in Milwaukee medicine began in 1930 when he returned from academic work at the University of Wisconsin and the School of Medicine at Columbia University. He interned at St Mary's Hospital in Milwaukee and joined the staff of the Shorewood Psychiatric Hospital of Milwaukee following in the footsteps of his famous father who was the first practicing alienist in this region, and the founder and builder of the Shorewood Hospital in the year of 1904. Assuming the medical directorship of the hospital about three years later, the capable younger Studley was soon caught up in the new era of psychiatry during and following World War II. He was to lead in a broad range of activities that greatly influenced other practitioners and specialties to accept psychiatry as an equal and full status medical specialty in the community. He gave freely of time and energy to the neurologic clinics of Milwaukee County Hospital, to the psychiatric teaching of Marquette medical students, and to the continuing education of his nurses and assistants. He was an Associate in Neurology on the Marquette faculty from 1937 to 1959 and Associate Clinical Professor from 1959 until retirement. His lectures were stimulating and sparkled with wit.

Early in his career, Doctor Studley undertook court responsibilities in the examination of psychiatric cases. He ultimately qualified himself as an expert in forensic psychiatry and during the last 25 or 30 years of his busy career was in continual demand by the Milwaukee courts. His testimony was crucial in many of the city's spectacular trials. For many years subsequent to 1949, Doctor Studley served as board member, and later as chairman, of the Wisconsin State Department of Welfare and Social Services; in this capacity he accomplished much in advancing more modern practices for rehabilitating the criminally insane.

Doctor Studley played the role of pioneer in the introduction and practice of the shock therapies in Wisconsin. Collaborating with Dr Roland Jefferson, insulin shock therapy for schizophrenia was first used at Shorewood Hospital. His work with electric shock therapy was classic and singularly free of complications. His experience in this field became very extensive gaining him wide recognition. When electric shock was restricted in California several years ago, his was an important voice in defense of this treatment.

With the development of other hospital psychiatric facilities in Milwaukee, Shorewood Hospital continued to be a prestigious center for inpatient care, widely sought by rich and poor alike. Doctor Studley, with the superb assistance of Mrs Studley, the hospital business manager, conducted a most idealistic institution with doors open to all, irrespective of financial circumstances, creed, or station of life. With hospital costs soaring astronomically elsewhere, Shorewood's costs were kept at a modest $35 daily rate and the hospital was still successful and profitable at the conclusion of its physical plant usefulness in 1978. At that time Doctor Studley retired to write, organize hospital records and history, and to enjoy some of his many personal interests.

Of the numerous exemplary accomplishments of this versatile physician, perhaps most important of all was his ability to inspire and motivate his students. Many of his junior staff assistants and externes went on in psychiatric careers. All of his staff, including attending physicians, responded to his professional dedication and charming personality with the greatest faith and loyalty. His optimism, enthusiasm, and cheerfulness comprised the dynamic center of the hospital's morale and were a big constructive influence in patient well-being and recovery.

I first met Doctor Studley in 1947, the year I entered practice in Milwaukee. His welcome was

warm and unreserved. He gave me vital assistance and encouragement for which I am forever grateful. Collaborating with him in the care of patients was always pleasant and rewarding.

On a more personal level, Bill Studley was uniformly popular and well-liked by his colleagues. His sunny charisma was always evident and vested him with great power of persuasion. He was an inveterate meeting attender, relished intellectual challenge, and was a great dinner companion. Many of his energies were devoted to the Milwaukee Neuropsychiatric Society. He served in all of its offices and, without question, was the Society's brightest guiding star throughout his entire professional life.

Other interesting facets of the Bill Studley career can be glimpsed through the man's lighter pursuits and hobbies. An accomplished arborist, his passion for planting and cultivating trees resulted in the Shorewood block becoming a sophisticated arboretum comprising many rare and beautiful specimens.

There was much enjoyable time with Bill, discussing trees, and planting and pruning them here, on our farm in the central Illinois countryside, and at his beloved retreat at his Aunt Kitty's in central Wisconsin. Aunt Kitty and her husband, Doctor Cooper, a country practitioner, were great favorites of Bill during his early adulthood, and visiting them in their 19th century cottage in Almond became a principal pastime for him. He loved and revered every square inch of these environs, was fascinated by the old fashioned household articles, planted fine trees and shrubs to further beautify the yard, and the town, and entertained his friends and colleagues there as often as possible.

Anyone to have known Bill Studley is fortunate. His generosity to everyone was one of his stellar characteristics. His philosophical, humorous sayings were always refreshing, and will continue to ring in our ears for a long time to come. The good things he has done for others are beyond count. He has been an inspiration to everyone within his reach, and, as stated at first, there can be no replacement!

—George E Moore, MD
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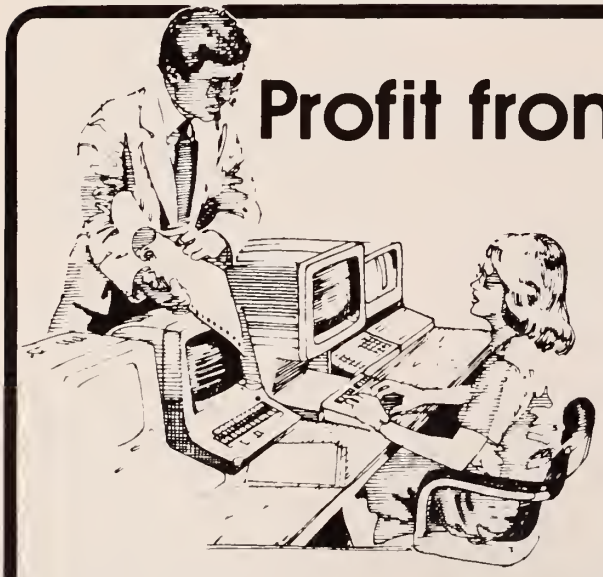

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Child abuse—After the report is made

A CHILD IS brought to a physicians's office. Abuse is suspected, and the mandatory report is made. But, what happens next? What wheels are set in motion to ensure that timely intervention takes place and that that child will not get "lost" in the system?

The common underlying goal is to provide a protective response system for children, generally through the county social services or protective services department. But, physicians fear that parents will withdraw their children from treatment if a report is made. To compound this, there is often an inability on the part of child protective workers to keep up with the ever-increasing amount of reports being made.

When physicians make a report, they frequently feel that they are sending the child off into a void, the unknown. They seldom have time to follow the reported cases. Often, on those rare occasions when they have tried to obtain information, it is not readily available.

Conflict arises in developing programs for the protection of children because of the underlying debate on whether children have rights of their own. Article .17 of the International Covenant on Civil and Political Rights (United Nations, December 16, 1966) states, "No one shall be subjected to arbitrary or unlawful interference with their privacy, family, home . . . Everyone has the right to the protection of the law against such interference."[1] The privacy of the home, however, may make it difficult to fulfill the United Nations' Declaration of the Rights of the Child: "The child shall be protected from all forms of neglect, cruelty, and exploitation."[2]

Professionals expert in child protection should work together to provide needed medical, social, and psychiatric services to families in which children have been abused and neglected. Development of a multidisciplinary team approach is a fairly new concept that has evolved in the last decade. Its growth, in part, has come from a need to relieve the overburdened social services departments which are unable to provide the many services needed by these families whose children are reported as victims. The emphasis is then placed on treatment and not just separation of the children from the home.

All too frequently physicians ignore or resist dealing with these cases because of limited experience, or an experience of a close colleague has been too emotionally draining. The agencies created to aid the families are

Table 1—*Services provided by result of investigation**

Services	Indicated Abuse	Indicated Neglect	Indicated Abuse & Neglect	Unfounded	Total	%
Caseworker	935	527	20	3,435	4,917	55.7
Homemaker	21	58	3	122	204	2.3
Day care	17	11	0	60	88	1.0
Foster care	107	111	13	135	366	4.1
Moved to relative's home	71	67	1	142	281	3.2
Shelter/ institutional care	36	7	1	55	99	1.1
Health/mental health	210	85	12	418	725	8.2
Financial assistance	45	34	6	175	260	2.9
Referred to 51 Board	149	32	7	253	441	5.0
Referred to other agency	147	21	5	490	663	7.5
Referred to juvenile court	247	115	14	229	605	6.9
Referred to criminal court	346	51	5	113	515	5.8
No services action taken	47	22	0	3,005	3,074	34.8
Other services provided	109	39	0	355	503	5.7

Totals in table do not equal total number of cases as more than one service is often provided in a case. Percentages are based on 8,821 cases or respondents.

*SOURCE: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse and Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

[1]International Covenant on Civil and Political Rights Article .17 United Nations General Assembly, December 16, 1966.
[2]Declaration of the Rights of the Child by the United Nations General Assembly, November 20, 1959.

overworked, and sometimes the cure for child abuse can be worse than the disease. The agencies that were established to deal with not only the short-term, crisis intervention but also the long-term support, fall far short of these expectations. The continuing rise in reported cases of abuse and neglect tax the system to the point where only early intervention can be accomplished, and the victim and perpetrator do not receive the long-term services necessary for rehabilitation.

Because child protection and therapeutic intervention are the primary objectives of the civil laws mandating reporting of suspected or blatant cases of abuse or neglect, physicians must keep this premise foremost in their minds. The reporting laws were *not* created to punish the perpetrator, but aid the child.

No two cases are alike, so it is difficult to describe what happens to a "typical" case after a case is reported. Similarities do exist as far as prescribed time frames and a predictable flow through the system, and these are outlined below.

According to Wisconsin law, the county agency must initiate a diligent investigation within 24 hours of a report to determine if the child is in need of protection or services. There may be those rare occasions when a physician may deem it improper or unadvisable to allow the child to be taken by the parents or legal guardian because of a fear that the child will be further injured. In those extreme cases, the physician should call the police *and* the county social services agency and explain the circumstances. The police will act immediately to take the child into protective custody.

The initial investigation of a reported case of abuse or neglect requires that a person from the county agency visit the child's home or living quarters. They are also free to contact, observe, or interview the child at any location without permission from the child's parents or legal guardian.

The person making the investigation must determine if *any* child in the home requires immediate protection, and, if so, the person must take the child into custody and deliver the child to a court intake worker.

If the county agency determines that a child, any member of the child's family, or the child's guardian or legal custodian is in need of services, the county agency must offer to provide appropriate services. If the child's parent, guardian, or legal custodian refuses to accept the services, the county agency may request that a petition be filed alleging that the child, who is the subject of the report, or any other child in the home, is in need of protection or services.

A determination of whether abuse or neglect has occurred or that the child has been threatened with an injury and that abuse of the child is likely to occur must be made by the county agent within 60 days after receipt of a report.

Under Act 172, the agency's determination of abuse or neglect must be based on *a preponderance of the evidence* produced by the investigation. A record must be maintained of actions taken in connection with each report the agency receives. Included in the record is a description of the services provided to any child and to the parents or legal guardian of the child, and the record must be updated every six months by the agency.

Within 60 days after the agency receives a report from a mandated reporter, the agency must inform the reporter what action, if any, was taken to protect the health and welfare of the child who is the subject of the report.

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must provide the Department with information about each report it receives and about each investigation it conducts. The information is to be used by the Department to monitor services provided. Nonidentifying information is used to maintain statewide statistics on child abuse and neglect and for planning and policy developments.

During the next several months, members of the Ad Hoc Committee on Child Abuse will be reviewing various established protocols from other states developed to aid the multidisciplinary team when examining and interviewing cases of child abuse and neglect. A protocol will be devised for Wisconsin physicians to follow and will be made available at the scheduled May 18, 1985, Child Abuse and Neglect Conference/Workshop to be held in Madison. Details of the upcoming meeting will appear in the April *WMJ*.

—Prepared by *Deb Powers*, Policy Analyst, SMS Physicians Alliance Division ■

Table 2—*Case disposition by result**

	Indicated Abuse	Indicated Neglect	Indicated Abuse & Neglect	Unfounded	Total
Child at home	96	371	6	6535	7819
Disposition pending	23	11	1	24	59
Voluntary placement	63	46	2	119	230
Court-ordered placement	86	99	12	129	326
Consent to adoption	0	2	0	1	3
Child died	2	2	0	5	9
Other	73	48	0	232	353
Unreported	811	0	0	22	23
TOTAL	1154	579	21	7068	8822
%	13.1	6.6	0.2	80.1	

*Source: Annual Report to the Governor and the Legislature on the Wisconsin Child Abuse & Neglect Act; Chapter 355, Laws of 1977, section 48.981; Division of Community Services, Dept of Health & Social Services, August 1, 1983.

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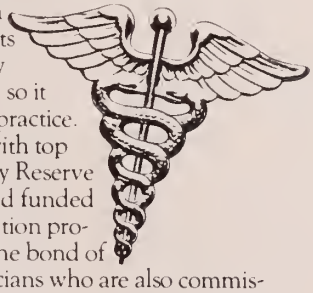

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Magnetic resonance imaging (MRI): View of the Wisconsin Radiological Society

Roland A Locher, MD, La Crosse

THE WISCONSIN Radiological Society, as the professional organization representing the group of radiologists practicing medicine in the State of Wisconsin, takes a vital interest in the variety of imaging techniques available to the specialty and the ability to offer these techniques to the general public. The increasing and sometimes awe-inspiring sophistication of modern medical equipment and the ability to use such equipment is counterbalanced by the frequently extraordinarily high cost of the equipment itself. It is not surprising, therefore, that vigorous efforts are being made by concerned citizens, third-party payers and local and state governments to limit medical expenditures. This occasionally results in the medical community being at odds with another group, as it had been up until recently with the Department of Health and Social Services (DHSS) of the State of Wisconsin regarding CT scanners.

The medical community foresaw the necessity of having a wide distribution of CT scanners throughout the state. The state, on the other hand, chose to wage, through its Certificate-of-Need process, a rather strong battle against the acquisition of CT scanners by a number of hospitals to the extent that suits were brought against the state by several hospitals claiming restraint of trade. Physicians in these various hospitals felt that their inability to obtain this remarkable new modality severely restricted their ability to offer high-quality medical care. Looking back, this seems unquestionably true, and to our knowledge the state lost all of the suits brought against it and has largely acceded that computerized tomography (CT) is a necessary device in the modern medical era.

A similar situation arises now with the advent of another modality known as nuclear magnetic resonance, or more commonly now, "magnetic resonance" or "magnetic resonance imaging" (MRI). This shows every sign of becoming as remarkable a diagnostic tool as CT has proved to be. It has already been shown to be the best modality available for the diagnosis of a variety of conditions, particularly within the nervous system. The Department of Health and Social Services of the State of Wisconsin has chosen to describe MRI as "innovative," and in so-doing, has restricted the acquisition of MRI to the medical schools at Madison and Milwaukee. In our view the term "innovative" as applied to MRI is unfortunate. It implies, it seems to us, not only a new modality but also, perhaps more appropriately, an unproven or experimental modality. The committee agrees that MRI is new; but, particularly as it applies to certain neurologic diseases, MRI is at this time no longer experimental.

The refusal of the Department of Health and Social Services to consider the application to acquire MRI of other institutions under the Capital Expenditure Review process (CER), provides the medical schools at Madison and Milwaukee with a *de facto* monopoly on this modality and may preclude patients across the state from having easy access to MRI. There are a number of large, active hospitals, consortia of hospitals and clinics across the state which need to be able to offer their patients magnetic resonance services. The road should be open for these institutions to obtain the modality, dependent upon the usual approval under the Capital Expenditure Review process and the patient volume necessary to provide the service at a reasonable cost. We see the latter as being largely governed in the very near future by the DRG system of reimbursement which will virtually force hospitals to obtain diagnoses in the most expeditious and least expensive manner. We expect that in many cases this will include magnetic resonance imaging.

The medical community has already realized that because of the expense of MRI, cooperation among groups in various areas allowing maximum utilization of each unit will be necessary to insure economic viability. Several groups or consortia have already

Members of the Committee on Magnetic Resonance Imaging of the Wisconsin Radiological Society

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submitted letters of intent to the DHSS. These have been turned down without formal review under the Capital Expenditure Review process. This is lamentable. We feel that each project should be fully reviewed and a decision for or against made on the merits of each.

In summary, this task force concludes and recommends that:

1. Insofar as imaging (not spectroscopy) is concerned, MRI is not to be considered innovative (*ie*, is not experimental).

2. The ultimate tremendous medical utility of CT was foreseen early on by the medical community and put to good use despite the restrictive attitude of the DHSS. Indeed, we have great reservation that these restrictions did any good at all and, ultimately, may have done more harm than good in restricting the availability of this most useful diagnostic tool to patients across the state. We, therefore, feel that the road to the acquisition of MRI should be open. The medical necessities and cost should be examined through the CER process and the DHSS should not refuse, out of hand, to receive applications. Each application should stand on its own merits, and decisions for or against approval should be made on that basis.

3. We firmly believe that the medical community in the State of Wisconsin is ethical and responsible and believe that the above will allow for and encourage orderly and financially and medically sound development of MRI in this state. ■

Suggested patient form for obtaining DES-exposure information

In an earlier edition of the *Wisconsin Medical Journal* (February 1985), physicians were encouraged to question all individuals born between 1940 and 1971 as to their mother's possible exposure to diethylstilbestrol (DES). Printed below is a suggested form which could facilitate this important questioning.

Patient history for DES exposure of individuals born between 1940 and 1971

Name: _____
Address: _____
Date of Birth: ____ / ____ / ____
Did your mother have any difficulties (spotting, miscarriages) with **any** of her pregnancies?
Yes ____ No ____ Don't know ____
Did your mother have any difficulties while she was carrying you?
Yes ____ No ____ Don't know ____
Did your mother take any medication (hormones) while she was pregnant with you?
No ____
Yes ____ What kind? _____
If you don't know, can you find out from your mother, her doctor, or the hospital where you were born (if your mother took any medication during her pregnancy with you)?
Yes ____ No ____ Don't know ____
Women: Have you had problems with your periods, vaginal discharges, or other symptoms? Please describe:

Men: Have you had, or been told you had, any problems with undescended testicle(s), abnormal sperm, or other symptoms? Please describe:

* * * * * * *

Women who became pregnant after 1940:
Did you have any difficulties (spotting, miscarriages) in any of your pregnancies?
Yes ____ No ____
Did you take any medication (hormones) during any of your pregnancies?
No ____
Yes ____ What kind? _____
If you don't know whether you took any medication during your pregnancies, can you find out from your doctor/hospital where you delivered and let us know?
Yes ____ No ____

SMS Committee on School Health member Conrad Andringa, MD, Madison, served as consultant to the AAP Committee on School Health in developing the adjacent policy statement on Alcohol Abuse Education in School.

Currently the Society's School Health Committee is working on several fronts to promote alcohol abuse education. The Committee is represented on the Wisconsin Coalition for School Health Education which recently completed a resource guide for Wisconsin health educators on materials available on health education, including alcohol abuse prevention. The coalition has also prepared a report on "Critical Health Problems of Wisconsin School Aged Youth" of which one section is devoted to discussing alcohol and other drug problems of Wisconsin's school children.

The Committee also has engaged in a joint television and radio public service campaign with the Wisconsin Broadcasters Association on preventing alcohol abuse. The first set of public service announcements was aimed at adolescents and featured well-known Wisconsin athletes urging moderation in alcohol consumption. Future PSAs are planned on the topics of fetal alcohol syndrome and parental responsibility in alcohol education.

For further information on this issue contact:

Conrad Andringa, MD
1313 Fish Hatchery Road
Madison, WI 53715
608/252-8181 ■

Pediatricians establish policy statement for alcohol abuse education in school

The American Academy of Pediatrics in cooperation with its local chapters has established a policy statement relative to alcohol abuse education in school. The statement was published in the AAP's November 1984 Bulletin and is reprinted below.

* * *

Alcohol abuse education in school

Alcohol abuse is a serious concern in our society. Its effect on the adult population has been well publicized. Addiction, spouse abuse, lost jobs, and driving while intoxicated, with its attendant risk of injury and death, are among the issues we hear about daily. For our children, the harm is equally great. The most dramatic examples are fetal alcohol syndrome, broken homes, and physical and mental abuse.

But the alcohol problem is even more directly a problem for many of our nation's young people. There are an estimated three million problem drinkers in the 13-to-17-year age group and more than 300,000 teenage alcoholics. Problem drinking often begins as early as the sixth or seventh grade, and it worsens in the high school years. Alcohol is a "socially acceptable" drug and is often openly abused. Adults, by word and example, contribute to the confusion regarding the distinction between use and abuse.

The financial cost of this abuse is high. Each year, more than $65 billion in public and private money is *known* to be spent and lost in dealing with the problems caused by alcohol abuse. The alcohol industry, meanwhile, spends more than $1 billion annually to encourage continued alcohol use; much of the advertising is directed at the youth market.

Because the problem is a multifaceted one and because we believe that education can be part of the solution, the Committee on School Health urges a coordinated campaign to provide our nation's children with appropriate information to combat the incessant peer and media pressure to drink. The Committee, therefore, recommends that:

1. A year-by-year educational program be incorporated in all school curricula (kindergarten through 12th grade) designed to make students aware of the problems associated with alcohol use and abuse;
2. Local AAP chapters work with parent-teacher organizations and other associations to promote awareness of the harm that results from encouraging the use of alcohol by our young people;
3. Local AAP chapters make themselves available to schools and school organizations to assist in this education process; and
4. Local AAP chapters use the media to promote alcohol abuse awareness programs to educate children both at home and in the school.

RECOMMENDED READING:

Alcohol, Tobacco and Firearms: Summary Statistics. Department of the Treasury: Bureau of Alcohol, Tobacco and Firearms, 1979.

Alcoholic Beverage Abuse Control: Wisconsin Dept of Health and Social Services, Division of Community Services, 1979.

Mayer JE, Filstead W, eds: *Adolescence and Alcohol.* Cambridge, MA: Ballinger Publ, 1980. ■

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Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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Endemic Kawasaki disease in rural Wisconsin

Thomas M Sutton, MD, MS and *Bradley Sullivan, MD, PhD*
Marshfield, Wisconsin

Abstract. *Between July 1977 and June 1984, twenty-two cases of Kawasaki disease (mucocutaneous lymph node syndrome) were seen at the Marshfield Clinic. All cases fulfilled the Centers for Disease Control (CDC) criteria for Kawasaki disease. Twenty-one cases occurred in white children with one native American child. All cases except one occurred in the rural population of North-central Wisconsin. Cases occurred with an even distribution over the study years with no epidemic outbreaks. Most cases occurred in the first half of the year. Four patients (18%) developed significant cardiovascular abnormalities. There were no deaths. Nineteen cases occurred in children less than five years of age. Among children less than five years of age, in our study area, the average annual incidence was 3.8 cases/100,000 children/year, which is much greater than expected, based on CDC information.*

Key words: Kawasaki disease, Mucocutaneous lymph node syndrome, Endemic infections

SINCE THE FIRST case of Kawasaki disease was described in the United States,[1] over 500 cases of Kawasaki disease have been recorded by the Centers for Disease Control (CDC).[2,3] Among these cases Kawasaki disease occurred significantly more frequently among Asians than in blacks or whites. Cardiovascular complications were noted in 22% of patients with death occurring in 1.2% of patients.[3] Several epidemic outbreaks have been noted since 1978.[4-9] A large outbreak was recently reported in Milwaukee, Wisconsin in 1982 in a bulletin from the State of Wisconsin, Department of Health and Social Services.[10] On review of the literature, there are no other descriptions of Kawasaki disease in the Midwest or in a rural, primarily white population in the United States.

Methods. The combined records of the Marshfield Clinic and St Joseph's Hospital, Marshfield, Wisconsin, were reviewed for patients with the diagnosis of Kawasaki disease or mucocutaneous lymph node syndrome. Between January 1, 1977 and June 1984 (90 months), 22 patients were found to fulfill the Centers for Disease Control (CDC) criteria for this disease. Analysis of these charts was performed to define the incidence and characteristics of Kawasaki disease in our service area.

Results. Twenty-one of 22 patients were caucasian with one native American child. There were 11 male and 11 female patients. Median age at onset was two years and ten months with a mean of three years and three months and a range of five months to 13 years and one month.

Clinical presentation in our patients was typical for Kawasaki disease. Mean maximal temperature was 39.8 C among 20 patients in whom this was recorded. There was a range of 38.3 C to 40.5 C. Mean duration of fever was 7.8 days with a range of five to 14 days. Eighteen of 22 patients (82%) had cervical adenopathy. All 22 patients had bilateral conjunctivitis, variable erythematous rash, and typical oral findings of strawberry tongue and cracking and fissuring of lips.

Erythrocyte sedimentation rate (ESR), Westergren method, was determined in 21 patients. Mean maximal ESR was 88 mm/hr with a range of 15 to 150 mm/hr. The white blood cell count per cu mm (WBC/mm^3) was determined in 20 patients. Mean maximal WBC was 16,600/mm^3 with a range of 8,100/mm^3 to 26,600/mm^3. Mean maximal platelet count determined in 15 patients was 784,000/mm^3 with a range of 380,000/mm^3 to 1,600,000/mm^3.

Electrocardiographic studies were performed during the acute stage of illness in 21 of 22 patients. Eight patients had sinus tachycardia. No patients had signs of acute ischemia or significant rhythm disturbance.

Thirteen patients had two-dimensional echocardiograms performed. Four patients were found to have significant cardiac involvement. All four were males ranging from 11 months to three years and six months. Two of these patients had small pericardial effusions which later resolved. One patient had multiple coronary artery aneurysms which later resolved. One patient had a dilated left main coronary artery which later returned to normal size. No heart catheterizations

From the Pediatrics Department, Marshfield Clinic, Marshfield. Reprint requests to: Thomas M Sutton, MD, MS, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449 (ph 715/387-5251). Copyright 1985 by the State Medical Society of Wisconsin.

were performed in any of our patients.

Nineteen of 21 patients were treated with aspirin alone. The other two received no treatment. There were no deaths during the acute or followup period in any patients. All patients identified with cardiac involvement are alive and well without apparent sequelae. Echocardiographic studies have returned to normal.

In addition to the previously mentioned cardiac abnormalities, several patients experienced other complications. These included one patient with hepatitis, one with ileus, one with pneumonia, one with hydropic gallbladder, one with arthritis and abdominal pain, and one with aseptic meningitis. All complications were transient in nature and resolved without sequelae.

All patients with the exception of one traveler from Southeastern Wisconsin were residents of the rural North-central Wisconsin area at the time of the onset of their illnesses. In the counties which represent our service area, there are no cities larger than 53,000 in population. Cases were fairly evenly distributed over the study period (Fig 1). Onset of illness showed mild clustering in the months of January and February, and also July and August, but no other trends were observed (Fig 2).

Considering the 21 patients who were permanent residents of our service area, the average annual incidence among children 13 years of age or less was 2.8 cases/year, or 1.54 cases/100,000 children/year. Considering only those 18 patients who were permanent residents of our service area and also less than five years of age, the annual incidence was 2.4 cases/year, or 3.82 cases/100,000/year. These rates are based on a 1980 census data by county for Wisconsin.

Discussion. Since the initial description of Kawasaki disease in the United States there have been numerous reports of outbreaks in large urban areas and in areas of high percentage of Asian population.[1-10] To our knowledge there have been no previously reported occurrences of endemic Kawasaki disease in a rural caucasian population, and we believe this is the first such report.

The average annual incidence during our study period was 3.82/cases/100,000/year for children less than five years of age. This can be compared to a national annual incidence of 0.59 cases/100,000 children younger than five years of age reported by the Centers for Disease Control between July 1976 and December 1980.[3] Our estimate for annual incidence also may be lower than the actual incidence since not all cases of Kawasaki disease in our area may have been diagnosed and not all cases may have been seen or treated at our institution. The reason for an increased annual incidence in our area is not clear.

Four of 22 patients (18%) were found to have significant cardiac involvement. While this is comparable to other large series,[2,3] this estimate may be low since echocardiographic studies were performed only on the 13 most recent patients. We believe it is significant that there were no deaths and no residual cardiovascular abnormalities on followup echocardiographic studies in these patients. We would support the use of echocardiography alone for following patients with cardiac involvement in the absence of ischemic symptoms.

Our findings demonstrate the endemic occurrence of Kawasaki disease in our predominantly rural caucasian population with a high annual incidence. Other practitioners should be alerted to this occurrence and should consider Kawasaki disease in the differential diagnoses of patients pre-

Figure 1—*Distribution of cases of Kawasaki disease by year of onset.*

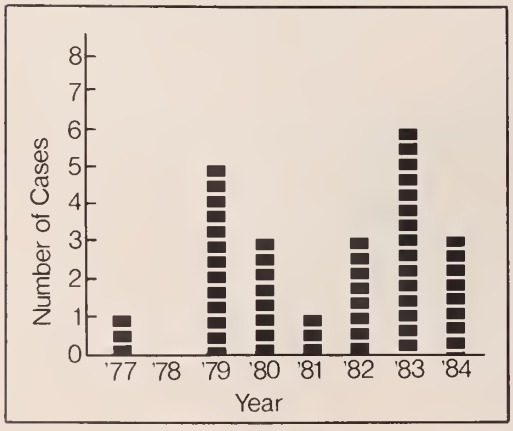
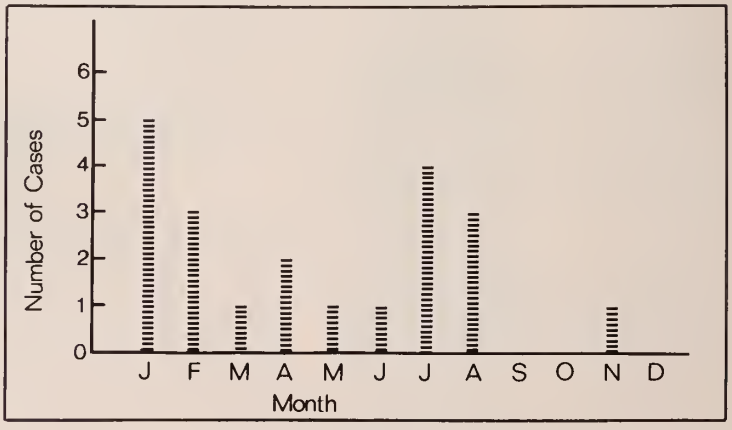


Figure 2—*Distribution of cases of Kawasaki disease by month of onset.*



senting with typical history, physical examination, and laboratory findings.

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Technetium^{99m}-pyrophosphate scintigraphy in amyloid cardiomyopathy

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Abstract. *The diagnosis of amyloid cardiomyopathy can be difficult due to the lack of specific studies short of myocardial biopsy. Recent reports suggest that technetium^{99m}-pyrophosphate (Tc^{99m}-PYP) scintigraphy may be of diagnostic value. Described below is a case showing the salient features of the scan in this disease.*

Key words: Amyloidosis, Technetium^{99m}-pyrophosphate scintigraphy

THE PRESENTATIONS of systemic amyloidosis are separated into three broad categories, primary, secondary, and senile. Although their pattern of distribution is individually different, all forms of the disease can infiltrate the heart. In the setting of myeloma, chronic inflammatory diseases, or advanced age, the onset of unexplained left ventricular dysfunction suggests the possibility of myocardial amyloidosis when bedside examination rules out more common causes of heart failure.[1-5]

Reprint requests to: Michael J Ptacin, MD, Section of Cardiology 111M, Wood Veterans Administration Medical Center, 5000 West National Ave, Wood, Wis 53193 (ph 414/384-2000). Copyright 1985 by the State Medical Society of Wisconsin.

Recently, technetium^{99m}-pyrophosphate (Tc^{99m}-PYP) scintigraphy has been shown to be a promising diagnostic technique as long as strict diagnostic criteria are used.[6-8] The following case shows that Tc^{99m}-PYP was a helpful adjunct in the diagnosis of amyloid cardiomyopathy.

Case 1. A 90-year-old white male was admitted to the hospital with the new onset of exertional dyspnea, orthopnea, and dementia. No history of hypertension, angina pectoris, myocardial infarction, or valvular disease could be elicited.

Physical examination revealed a disoriented white male in moderate respiratory distress. His pulse was 100 beats per minute and irregularly irregular. Blood pressure was 100/70 mmHg. Jugular venous distention to the angle of the jaw at 90° was present. Specific wave forms could not be discerned. The first heart sound's intensity was variable. Paradoxical splitting of the second heart sound was noted. A loud third sound was audible at the apex. A grade II/VI apical systolic murmur was heard at the apex, radiating towards the axilla. The liver was 16 cm in span and was without systolic pulsation. Diffuse bibasilar râles and pleural effusions were evident. Mild peripheral edema was noted. Electrocardiographic studies revealed an atrial flutter and a complete left bundle branch block. Cardiomegaly, pulmonary vascular congestion, and pleural effusions were noted bilaterally on chest x-ray film.

Two-dimensional echocardiographic (2DE) studies revealed marked left and right ventricular hypertrophy. The mitral valve and interatrial septum were thickened. The ventricular myocardium displayed a fine granular appearance suggesting an infiltrative myocardial process. A small pericardial effusion was present.

In view of the patient's advanced age, and a suggestion of myocardial infiltration by 2DE, amyloid cardiomyopathy was suspected. A Tc^{99m}-PYP scan showed 4+ diffuse uptake in the right and left ventricular myocardium (Fig 1). Both ventricles appeared to be hypertrophied. The diffuse uptake of Tc^{99m}-PYP and infiltrative appearance of the myocardium by 2DE was strongly suggestive of amyloid cardiomyopathy. Rectal biopsy confirmed the suspicion of

systemic amyloidosis. Waldenstrom's macroglobulinema was diagnosed when an IgM gammopathy was found in the serum and diffuse lymphocytoid lymphocyte infiltration was found in the bone marrow and was felt responsible for his systemic amyloidosis.

Discussion. Systemic amyloidosis is classified in major categories which are defined by the specific type of amyloid protein and presumed pattern of infiltration. These patterns are arbitrary but the potential for cardiac involvement in all should be recognized.[1-5] The diagnosis of amyloid cardiomyopathy can be difficult. It represents approximately 5 percent of noncoronary cardiomyopathies.[3] Outside of a high clinical suspicion, physical examination, electrocardiographic studies, and chest x-ray films do not provide specific information to support the diagnosis. In general these techniques point to a restrictive myocardial process of the noncoronary type. When a patient susceptible to amyloidosis (one with multiple myeloma, chronic inflammatory state, or advanced age) presents with advanced biventricular failure, amyloid cardiomyopathy should be suspected.

In symptomatic patients the Tc^{99m}-PYP scan strongly favors amyloidosis when: (1) biventricular uptake is present, (2) the intensity of the tracer is greater than sternal activity, (3) concentric thickening of the left ventricle is noted, (4) concomitant uptake of the tracer is noted over the liver, (5) other etiologies for tracer uptake such as myocardial infarction, cardiac tumor or trauma, metastatic calcification, myocarditis or post-cardioversion changes are eliminated. The exact mechanism for the strong uptake of tracer is unclear. Amyloid material from the liver is known to have a high content of calcium. Whether affinity of the tracer for calcium explains this has not been elucidated.[6-12]

When compared with two-dimensional echocardiographic studies, the magnitude of tracer uptake tends to correlate with left ventricular thickness. As can be appreciated, the present criteria are relatively strict. The ability to detect early amyloid infiltration has not been adequately evaluated. Larger studies in patients with biopsy-proven amyloid cardiomyopathy are necessary to define the sensitivity and specificity of this study.

Where the Tc^{99m}-PYP scan stands in the diagnostic algorithm for amyloid cardiomyopathy remains unclear. Recent reports suggest that two-dimensional echocardiography is sensitive even in early infiltrative states.[13-18] The key to premortem diagnosis appears to be a high index of clinical suspicion, and through physical examination, electrocardiography and chest x-ray film eliciting a restrictive myocardial process. Anatomic confirmation using two-dimensional echocardiography or Tc^{99m}-PYP may alleviate the need for a tissue diagnosis.

Summary. The Tc^{99m}-PYP scan can be used to detect or confirm amyloid cardiomyopathy in symptomatic patients when strict diagnostic criteria are used.

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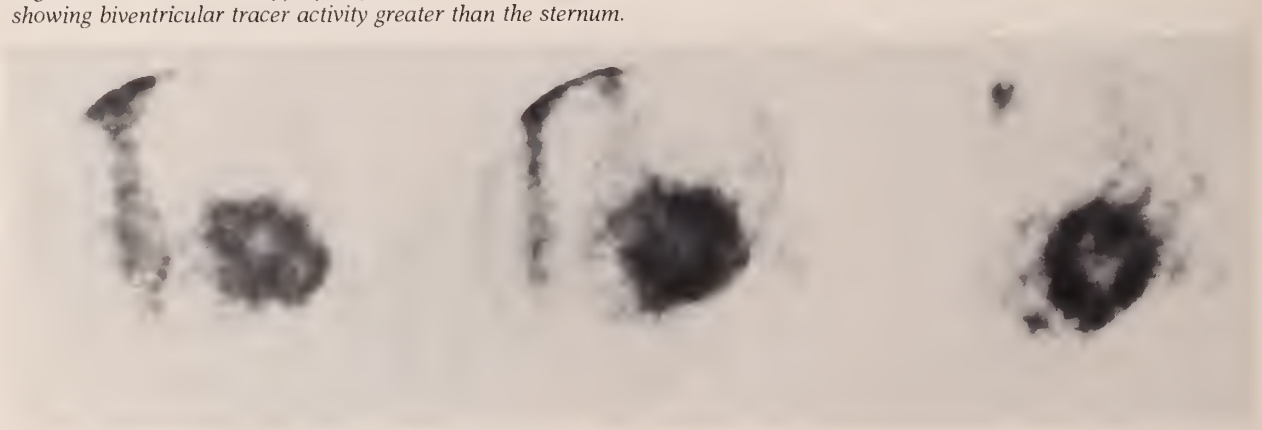
Figure 1—*Technetium^{99m}-pyrophosphate scan of a patient with biopsy-proven amyloid cardiomyopathy showing biventricular tracer activity greater than the sternum.*



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All contact lenses have protein deposits

All soft contact lenses have protein adherent to their surface as a result of normal wear, according to a new study in the February *Archives of Ophthalmology*. The surface deposits are capable of decreasing the life of a lens, causing discomfort and contributing to blurred image. Olafur G Gudmundsson, MD, of Harvard Medical School, and colleagues examined worn soft contact lenses from five asymptomatic subjects by immunofluorescence microscopy for type of protein on the lens surface. They found lysozyme, IgA, lactoferrin, and IgG. "New, never-worn soft contact lenses did not stain for any of the proteins examined in this study," the researchers report. ■

Immune system deficiency related to depression

Decreased lymphocyte function appears to be associated specifically with clinical depression and not to effects of hospitalization or to other psychiatric disorders, according to a study from New York's Mount Sinai School of Medicine. Writing in the February *Archives of General Psychiatry,* Steven J Schleifer, MD, and colleagues say they compared lymphocyte responses of ambulatory patients with major depressive disorder with those of matched controls. They also compared responses of hospitalized schizophrenic patients with those hospitalized for elective surgery. Study results suggest that "altered immunity in depression may be related to severity of depressive symptoms," they say. ■

Report new technique for studying kidney function

Correction of a dangerous buildup of acid in kidney tissue can be gained by administration of adenosine triphosphate (ATP)-magnesium chloride, according to a new study in the February *Archives of Surgery*. Bauer E Sumpio, MD, PhD, and colleagues from Yale University School of Medicine say they were able to track molecular events in intact living cells and perfused kidneys by using high-resolution phosphate 31-nuclear magnetic resonance spectroscopy. Using animal models, they were able to correct intracellular acidosis within 75 minutes, following blood-flow stoppage and reperfusion. ATP levels increased to 69 percent within ten minutes, they say. ■

Spinal-cord patients can be independent

Most patients can anticipate a satisfying independent life following spinal cord injury, according to a study from the St Louis Veterans Administration Medical Center appearing in the February *Archives of Neurology*. Robert M Woolsey, MD, followed the rehabilitation outcome of 100 consecutive patients. Among his findings: "About half of our patients with incomplete injuries regained the ability to walk. Almost all complete paraplegic and quadriplegic patients with lower-level injuries were able to live independently. Many resumed work or school. Unfortunately, the outlook for patients with higher-level injuries and for elderly or poorly motivated patients remains bleak." Of the 100 patients, 43 sustained injuries in auto accidents. ■

Legal aspects of medical genetics in Wisconsin

Ellen Wright Clayton, JD, Madison, Wisconsin

Abstract. *This article addresses several of the legal issues arising from recent advances in medical genetics that affect physicians in Wisconsin. Either in caring for their own patients or in responding to telephone consultations, practitioners who do not use reasonable care in detecting genetic risks or who fail to disclose those risks that a reasonable prospective parent would want to know may be liable at least for the additional expenses involved in caring for an affected child. Physicians who conscientiously object need not provide genetic counseling or prenatal diagnosis, but they are required nonetheless to use reasonable care in detecting which of their patients are at risk, to disclose those risks, and to offer to refer them elsewhere. Although patients usually have a right to confidentiality, the risk of genetic disorders for family members in some instances is so great that physicians may be justified in conveying this information to relatives at risk even over their patients' objections. As evidence of a public policy in favor of making genetic information available, the Wisconsin Legislature recently established procedures to enable adopted children to obtain such information about their biologic parents. Currently, there is no way to obtain a court order authorizing the sterilization of a mentally retarded person, no matter whether the procedure is requested for genetic or for other reasons.*

Key words: Medical genetics, Genetic counseling, Legal issues, Laws of Wisconsin

IN THE LAST decade, several factors have converged to increase the interest in the legal implications of medical genetics among physicians, lawyers, and society at large.

First, the explosion of molecular genetics has added powerful new techniques to the tools of pedigree analysis and clinical examination traditionally used in medical genetics. Many more genetic disorders have been recognized, and the availability of screening for carriers of numerous deleterious genes and of prenatal diagnosis for an increasing array of disorders can offer many prospective parents greater certainty rather than statements of probability.

Second, the legalization of abortion in 1973 made the use prenatal diagnosis and selective termination a more realistic option. The availability of effective modes of contraception and sterilization similarly enabled couples at risk more easily to avoid childbearing altogether either if they were opposed to selective abortion or if prenatal diagnosis were not an alternative.

Finally, the increasing desire of patients to have more control over their own health and over their reproductive decisions has been reflected in a greater willingness on the part of patients to seek legislative and judicial protection of their interests.

The analysis that follows discusses several legal problems involving medical genetics that commonly confront individual health care providers in Wisconsin. Medical geneticists and genetics associates are not the only practitioners affected. Obstetricians and pediatricians frequently must address these issues, too, and, from time to time, most other medical specialists are touched by medical genetics. This analysis focuses on Wisconsin law and points out both where the rules are clear and where they are still undecided. The separate, but substantial, legal issues surrounding genetic screening are not addressed.

1. The prototypical genetic counseling case

The most commonly litigated problem in medical genetics is the doctor's failure to tell prospective parents that they are at risk for having a defective child. The physician may simply have missed a potentially heritable disorder in the family history or may have failed to diagnose such a trait in the prospective parents' prior offspring. Problems also arise when physicians or laboratory personnel mishandle samples.

These cases are usually decided according to the dictates of medical malpractice law, an area of tort law. In order to win, the parties who bring these suits—the parents and often the affected child—must prove four facts.

1. They must prove that the party being sued—usually the doctor—owed the plaintiffs some *duty.* In

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the usual situation, the mother is the physician's actual patient, but the courts hold that the doctor's legal obligation extends to the father and the unborn child as well. The courts justify this extended duty on the basis that physicians surely must foresee that the father and the unborn child will be significantly affected by the care given to the mother.[1] This analysis was implicitly applied by the Wisconsin Supreme Court.[2]

In another commonly encountered situation, the doctor is a pediatrician or family practitioner caring for a child with, for example, cystic fibrosis or congenital deafness who fails either to diagnose the disorder or to recognize a risk for recurrence. The courts hold that the physicians who treat these children owe a duty not only to the affected child but also to the parents and to any future siblings.[3]

2. They must prove that the physician failed to fulfill his duty. This failure is termed *negligence.* It is important to recognize that negligence in the law does not mean "mistake" or imply any morally culpable act. Instead, it means simply the failure to comply with the governing standard of care. In genetic counseling, there are two components to the standard of care. The first governs the extent of the doctor's *duty to know* about the genetic risk. A physician must use that degree of care exercised by other reasonable similarly situated practitioners, both in the extent of their medical knowledge and in their performance of diagnostic procedures.[4]

More highly trained specialists must exercise greater skill than general practitioners. All physicians, however, have an obligation to "keep up," and all must use reasonable care in determining when referral to a medical geneticist is appropriate. Significantly, this rule also means that mistakes made when one is using reasonable care do not lead to liability.

The second component governs the extent of the physician's *duty to disclose* genetic risks to prospective parents. This issue raises questions of informed consent, for which there are two general rules. Some states hold that doctors are responsible for telling patients only what other *reasonable practitioners* would tell.[5] Other states, including Wisconsin, hold that physicians must tell patients what other *reasonable patients* would want to know.[6]

"More highly trained specialists must exercise greater skill than general practitioners. All physicians, however, have an obligation to 'keep up,' and all must use reasonable care in determining when referral to a medical geneticist is appropriate. Significantly, this rule also means that mistakes made when one is using reasonable care do not lead to liability."

3. They must prove that the physician's breach of duty was the *proximate cause* of the plaintiff's injuries. Analytically, one can see that any given action can have virtually endless ramifications, like ripples in a pond, but the law imposes liability only for those events that follow "proximately" or relatively directly from the initial negligent act. In the usual case, the parents must show that had they been given adequate genetic risk information, they would not have had the child. Wisconsin law may also require parents to show that similarly situated reasonable parents would also have elected not to have the child.[6]

4. They must prove that the plaintiffs suffered *legally compensable injuries.* In general, plaintiffs usually seek three types of damages: (a) the parents' cost of caring for the affected child; (b) the parents' emotional pain and suffering; and (c) the child's claim for his/her own injuries—the so-called "wrongful life" claim.

The states differ significantly in their decisions about whether, as a matter of public policy, any or all of these damages should be recoverable. Wisconsin has ruled that parents may recover the additional expenses involved in caring for an affected child,[2] but not the "ordinary" childrearing expenses.[7] The courts here have not ruled on the parents' claim for emotional pain and suffering, and it is not clear how they would respond were the issue to be raised.

Finally, Wisconsin has denied the affected child's claim for damages.[2] Interestingly, in reaching this decision denying the "wrongful life" claim, the Wisconsin Supreme Court relied heavily on a New Jersey decision[8] that was recently overruled by the New Jersey Supreme Court.[1] This does not mean, however, that the Wisconsin Court would reverse its ruling were it to address another "wrongful life" claim in the future.

II. Telephone inquiries

The answer to the question of what duty is owed by a health care provider to a person who simply calls on the telephone and is never seen in the office turns on the issue of when the doctor-patient relationship arises, a matter determined largely by the law

of contracts. Generally, a contract exists between two people only when one party makes an offer that the other accepts, both understand the content of the agreement, and both agree to exchange something of value with the other. In addition, a physician is free to refuse to enter into a contractual relationship with a patient.

Despite these formal rules, which would seem to make the presence of a physician-patient relationship hard to demonstrate, the law of contracts is altered somewhat in dealings between physicians and patients because a relatively uninformed person, the patient, is likely to rely on the statements and actions of another more knowledgeable person, the physician. In response to this marked inequality of position, the law is quick to find that a contractual relationship exists. Although a contract usually contains an implicit duty on the part of the patient to pay, the physician's general duties under the contract may nonetheless be enforceable even when it is understood that the patient will not pay.[9]

In light of this low threshold for the physician-patient relationship, it seems likely that the relationship arises in a simple telephone inquiry once the provider begins to give medical information to the caller. At this point, the usual duties—the reasonable practitioner standard of knowledge and the reasonable patient standard of disclosure—apply. This does not mean that one should refuse to answer questions on the telephone. It does mean that one should use reasonable care in deciding which questions may appropriately be answered without seeing the patient and in providing those answers. Although documentation is not legally required, it is sound practice here, as in all areas of medical care, routinely to note the substance of such conversations.

III. The conscientiously objecting physician

In some cases of inadequate disclosure, physicians have argued in defense that they deliberately refused to disclose genetic risk information because they objected to abortion. Conscientiously objecting health care professionals cannot be forced to participate in performing abortions. This is particularly clear in institutions receiving federal funds because Congress has enacted a law specifically protecting this right.[10] From this, it might be argued that health care providers have a right to avoid any connection whatsoever with abortion, no matter how distant. Yet the physician's refusal to provide such information may have a much more profound impact on a woman's reproductive decision-making than does the refusal to perform abortions.

For practical purposes, most women learn of genetic risks only from their physicians so that a refusal to disclose such risks means that some women would not know of factors that might lead them to seek abortion. By contrast, if a woman knows that she wishes to obtain an abortion but her physician refuses, she has the option of seeking out a doctor who will provide this service.

In light of the effect of withholding genetic risk information, the courts of Washington[11] and Michigan[12] have held that conscientiously objecting physicians are required to use reasonable care in detecting which of their patients are at risk to disclose the risk, and to offer to refer them elsewhere. They need not, of course, "counsel" abortion, particularly since most genetic counselors do not actually recommend abortion but rather discuss the options available to couples at risk. This places a minimal burden on physicians while preserving their patients' opportunity to make informed reproductive decisions.

IV. Confidentiality—disclosure to relatives who are at risk

When patients are told that they carry a genetic defect such as a chromosome translocation or X-linked recessive trait that represents increased risk to their relatives, they usually agree to cooperate in informing their relatives. In some situations, however, the patients may refuse to share this information with family members. As a general rule, patients have the privilege to require that their communications with physicians not be disclosed to third parties.[13] Although there have been no reported cases involving unwanted disclosure to relatives, a physician's breach of confidentiality can give rise to liability for damages for mental pain and suffering, humiliation, and loss of reputation.[14]

There are several recognized exceptions to the patient's privilege in which his or her confidentiality not only may but must be breached in order to prevent harm to third parties. For instance, many states, including Wisconsin, require that persons with certain infectious diseases be reported to public health authorities.[15] By analogy, there is growing consensus that there may be circumstances in which the risk of genetic disorders in the offspring of the patient's siblings is so great that the doctor may be justified in breaching the patient's confidence. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recently suggested that such disclosures can be made:

> . . . if and only if the following four conditions are met: (a) reasonable efforts to elicit voluntary consent to disclosure have failed; (b) there is a high probability both that harm will

occur if the information is withheld and that the disclosed information will actually be used to avert harm; (c) the harm that identifiable individuals would suffer if the information is not disclosed would be serious; and (d) appropriate precautions are taken to ensure that only the genetic information needed for diagnosis and/or treatment of the disease in question is disclosed.[16]

Although the report of the President's Commission is quite persuasive, compliance with its suggestions will not necessarily protect practitioners from liability. The law in Wisconsin about when physicians may reasonably disclose genetic risk information to relatives over a patient's objection will not be entirely clear until the courts or the Legislature address the issue. By far the safest course of action, then, is prophylactically to dispel the counselee's expectation of privacy or confidentiality by establishing criteria in advance for deciding when relatives should be sought out and by telling all patients about these guidelines at the beginning of the counseling process. So long as any subsequent disclosures and inquiries are no broader than reasonably necessary and made with due care, therre can be no liability.[17]

V. Confidentiality—opening adoption records

States have traditionally required that adoption records be sealed, citing interests in promoting adoption, the integrity of the adoptive family, and the privacy of the biologic parents. Recently, these statutes have come under considerable attack. While these statutes have uniformly been upheld as constitutional, several courts have suggested that adoption records can be opened for good cause, including the adopted child's need for medical or genetic information.[18] The President's Commission has strongly recommended that adoption statutes be altered to ensure access to such information.[16]

In 1981, before the Commission issued its report, Wisconsin revised its adoption law to make genetic and medical information much more easily available.[19] Under the new law, the parents of a child placed for adoption or removed from the home after February 1, 1982 are required to provide extensive medical and genetic information; parents of children placed before that date are encouraged to provide such information. This information, after removal of identifying data, is to be made available to, among others, the child after the age of 18 or to the child's adoptive parents or guardians before that age.

If the medical and genetic records are incomplete, the statute provides mechanisms to obtain additional information from the biologic parents, but the request for such a search must be accompanied by a physician's statement "either that the [adopted person] has or may have acquired a genetically transferable disease or that the [adopted person's] medical condition requires access to the information." Finally, the statute provides that any report of a genetic disorder in either the adopted child or his siblings and/or biologic parents is to be given to the biologic parents or to the adopted child, respectively.

The President's Commission has also recommended that children who are conceived by artificial insemination by donor (AID) should have access to genetic information about the donor.[16] This is particularly compelling in those relatively common situations where AID is used specifically to avoid passing on an undesirable genetic trait carried by the husband. Wisconsin, however, has not revised its AID statute to ensure that such information be made available.[20]

VI. Sterilization of the mentally retarded

The courts recently have been presented with numerous petitions to authorize the sterilization of mentally retarded individuals. The reasons offered in support of sterilization vary from case to case, but include: (1) prevention of inheritable causes of mental retardation in the offspring, an argument from genetics or eugenics; (2) the inability of the retarded person both to control her sexual activity and to cope with the trauma of pregnancy and childbirth, an argument often phrased in terms of the retarded person's "best interests"; and (3) the inability of the retarded person to provide adequate parental nurture, an argument based both on the child's interests and on the avoidance of burdens on the state.

In responding to these petitions, the courts in various states have discussed not only the propriety of using any of these arguments to justify sterilization but also the question of whether the courts have the authority in these cases to grant judicial approval.[21]

In In re *Eberhardy*,[22] a deeply divided and highly controversial decision, the Wisconsin Supreme Court decided that the courts had jurisdiction to rule on petitions for the sterilization of incompetent mentally retarded persons. The Court, however, ruled that the policy issues involving sterilization were so complex that the courts would not exercise their power until the Legislature decided when sterilization was actually in the "best interests" of a retarded person.

In its conclusion, the Court added that it could, at some future time, reverse its decision and choose to rule on petitions for sterilization of the mentally retarded if it became clear that the Legislature was not going to act in this area and if the appropriate case were presented. Since the

Wisconsin Supreme Court held that it would not rule on these petitions at all, it did not decide which, if any, reasons would be sufficient to justify sterilization. It did note in passing that the Legislature's recent repeal of a eugenic sterilization law could be interpreted as disapproval of sterilization for genetic reasons.

The *Eberhardy* court's refusal to rule on sterilization petitions has come under heavy attack, particularly in light of its statement that it might choose to decide this issue in the future. The Legislature has not responded to the *Eberhardy* decision. Thus, there is no way for parents and physicians to obtain prior approval from the courts for the sterilization of a mentally retarded person. This leaves them open to potential liability if they proceed with sterilization under both tort and constitutional law for deprivation of the retarded person's right to have children. The courts' refusal to grant prior protection does not necessarily mean that they will decline to impose liability if sterilizations were performed for inappropriate reasons. Physicians and parents who believe that sterilization of the mentally retarded may in some instances be justifiable must pursue vigorously their legislative remedies and perhaps should seek further judicial review.

Conclusion. The increasing power of medical genetics has created a whole array of pressing legal issues. In Wisconsin the judicial resolution of some of these problems provides substantial guidance to health care providers, particularly with regard to the physician's duty to know about and to disclose genetic risk information. Similarly, the Wisconsin Legislature made a great stride forward in its revision of the adoption statute to ensure adoptees' access to medical and genetic information about their biologic families.

"The increasing power of medical genetics has created a whole array of pressing legal issues. In Wisconsin the judicial resolution of some of these problems provides substantial guidance to health care providers, particularly with regard to the physician's duty to know about and to disclose genetic risk information. Similarly, the Wisconsin Legislature made a great stride forward in its revision of the adoption statute to ensure adoptees' access to medical and genetic information about their biologic families."

Many issues, however, have not yet been presented to the courts, leaving areas of uncertainty which will be resolved only by future litigation or possibly by legislative action. Some areas, in particular, such as revision of the AID statute and development of guidelines for the sterilization of the mentally retarded, clearly require legislative attention that they have not received.

The existence of these areas of uncertainty about legal issues has two significant implications for health care providers. First, it means that ethical norms, which must guide all medical practice and which often require more of practitioners than does the law, are particularly important in areas where the legal rules are unclear. Secondly, it suggests that providers have an obligation to participate in the legislative process in order to resolve some of the as yet unanswered questions for the benefit of themselves and of their patients.

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Physician morbidity: a limited study

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Abstract. *Physicians as patients have been identified as a group at risk for inadequate evaluation and treatment of illness in their resistance to seek regular medical care. One hundred and fifty Milwaukee area physicians, 50 each from internal medicine, surgery, and psychiatry, were surveyed for the purpose of obtaining data in the number, age, gender, chief complaints, and diagnoses of doctor-patients from 1977-1982. Of the 361 physician-patients identified, 94% were male and more than 50% had consulted surgeons. The male/female ratio was considerably lower among those who saw psychiatrists. Approximately a third of responders indicated physician-patients had problems with alcohol, depression, and anxiety. Morbidity pattern and health needs could not be defined by the data, but further study may benefit physicians as patients and those who treat them.*

Key words: Physician morbidity, Impaired physician, Physician-patient, Epidemiology

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ILLNESS, a disruption of most people's lives, may be doubly difficult when it occurs in the life of a physician. Illness seems to undermine the physician-patient's sense of both personal and professional identity.[1]

All aspects of care pose problems for the physician, beginning with neglect of his own health and an unwillingness to admit or recognize symptoms to grudging and half-hearted attempts to arrange for treatment, and culminating in devious and noncooperative efforts with the treating physician or a treatment regimen.

Healthcare professionals, intrigued by this situation, have concluded that doctors fear death and disease and that they work hard to combat them for their patients, but not for themselves. Indeed, they may become so imbued with the magic and protection of the doctor's role, they "may use their own knowledge and skills to defend themselves against their own anxiety . . ."[2]

Ten years ago an article classified doctor-patients into four groups. The smallest group consisted of doctors who had yearly physicals and followed the advice of their doctor. The largest group was composed of those doctors who willfully neglected their own health and put out of mind any disturbing signs or symptoms of disease.[3]

Because of issues like these, we were interested in learning to whom physicians turned when they needed a doctor. Our study had three aims: to determine a sample number of physicians seeking medical attention; to investigate the presenting health problems of physician patients as well as the diagnoses made by the doctors treating their colleagues, and to examine some of the characteristics of the physician-patients, including gender and age and area of medical practice.

METHOD.

Study population. One hundred and fifty Milwaukee area physicians were asked to participate in this study, 50 each from the practice areas of internal medicine, general surgery, and psychiatry. These physicians were randomly selected from the internists, surgeons, and psychiatrists listed in the 1980 Milwaukee Telephone Yellow Pages. The telephone listing is a select population, noteably deficient in medical school-based physicians.

Instrument. A letter of introduction, a questionnaire, and a stamped, self-addressed envelope were sent to the offices of the physicians in the study population. The survey design reflected a need for simplicity and brevity while protecting physician and patient anonymity. Responding physicians were not requested to identify themselves, their specialties, or physician-patients. Questionnaires sent to surgeons, internists, and psychiatrists differed in the list of diagnoses presented for classification of their physician patients and were thereby distinguished and grouped upon return.

RESULTS

Response. A response was received from 40% of all doctors (n = 150) who were sent questionnaires. Twenty-two surgeons, 20 internists, and 18 psychiatrists returned the questionnaire.

Number of doctors treating physician-patients. Among the 60 physicians who responded to the questionnaire, 49 (81%) reported at least one physician-patient in their medical practice in previous five years. Eighteen of 22 respond-

ing surgeons reported physician-patients (82%). Nineteen of 20 responding internists reported physician-patients (90%). Thirteen of 18 responding psychiatrists reported physician-patients (72%).

Number of physician-patients. The 60 physicians returning questionnaires reported a total of 361 physician-patients within their medical practices over the five years. The mean is six physician-patients per respondent.

Of the 361 physician-patients identified by the total respondents:

192 (53%) were seen by surgeons,
108 (30%) by internists, and
61 (17%) by psychiatrists.

Gender of physician-patients. Gender identification was provided for 345 of the 361 physician-patients described in the total respondent population. Male physician-patients predominated representing about 94% of the total number.

Table 1—*Ratio of number of men physician-patients to number of women physician-patients*

TOTAL RESPONDENT POPULATION	
SURGEONS	17:1
INTERNISTS	26:1
PSYCHIATRISTS	7:1

An examination of the ratios of men to women physician-patients (Table 1) illustrates a fairly pronounced difference between surgeons, internists, and psychiatrists. Note that surgeons and internists report a men-to-women ratio of about 20:1. In contrast, psychiatrists report a much smaller ratio of around 6:1.

Physician-patients' chief complaints. The questionnaire asked physicians to list, but not to quantify, the most common chief complaints presented by their physician-patients.

Surgeons reported only physical chief complaints (distinguished from psychological) among their physician-patients. Gastrointestinal chief complaints were recognized by three of the surgeons, while cardiovascular problems, genitourinary problems and hernia were each reported by two surgeons. Both respiratory-ear, nose, and throat and neurologic chief complaints were each identified by one surgeon.

Internists, in contrast with the surgeons, described a greater variety of physician-patients' chief complaints, including both physical and psychological problems. Seven internists listed cardiovascular problems as physician-patient chief complaints. With the exceptions of hernia and genitourinary problems, internists described chief complaints in most broad categories of physical illness, including gastrointestinal problems, respiratory problems, malignancy, metabolic disorder, neurologic disorder, infection, and obesity. In addition to the somatic chief complaints, three internists reported depression and problems with drugs or alcohol in their physician patients.

The psychiatrists found no purely physical complaints among their physician-patient's chief complaints. A majority of psychiatrists listed depression. Marital problems were identified as physician-patient chief complaints by six psychiatrists. Chief complaints of anxiety and alcohol/drug problems were each reported by four of the psychiatrists.

DISCUSSION

Response. The 40% response to the questionnaire may not be a representative sample of the study population. Information concerning the expected rate of response among a physician study population is not presently available in the literature.

Although the distributed number of responses from surgeons, internists, and psychiatrists did not differ significantly, some interesting differences were noted in the characteristics of response. Considered as a group, surgeons tended to return their questionnaires rapidly, providing less than complete information. In contrast, psychiatrists tended to return completed questionnaires, taking a considerable length of time to respond. Internists seemed to respond in a pattern between that of surgeons and psychiatrists; moderately complete questionnaires returned fairly rapidly.

Number of doctors treating physician-patients. Unfortunately the study does not offer a basis for quantifying use of physician services by physician-patients compared to nonphysician-patients. Although the majority of responding doctors (81%) reported having fellow physicians as patients during the last five years, the sample did not select randomly among all practicing physicians in a community surrounding a major medical center and thus may not be representative. The self-selected responders did provide a finite number of physician-patients to consider.

Number of physician-patients. Just over one-half of all physician-patients recognized by this study were patients of surgeons. The tendency of surgeons to have a considerably greater portion of the physician-patient population than either internists or psychiatrists may suggest that physicians rely upon self-treatment until problems arise which largely prohibit self-treatment (*ie,* surgical care).

Ages of physician-patients. Although information on age was not supplied for many of the physician-patients described by this

study, a simple comparison of age distribution for patients of internists versus psychiatrists merits discussion. As might be anticipated for the internist, generally providing well-rounded primary care for adults of all ages, ages of physician-patients were fairly evenly distributed from age 30 upward. In rather marked contrast to the internists' pattern, physician-patients of psychiatrists tended to be concentrated in the 40- through 60-year age range. Perhaps the socalled "mid-life crisis," an age of disappointment, disenchantment and disillusionment, prompts the middle-age physician to more readily seek psychiatric help. Insufficient data from the surgeons on ages of their physician-patients precludes discussion.

Gender of physician-patients. This study demonstrated a thought-provoking difference among physician-patients of psychiatrists, surgeons, and internists, with regard to gender distribution. While both surgeons and internists reported a male-to-female physician-patient ratio close to 20:1, psychiatrists reported a ratio of about 6:1. Several hypotheses may be further investigated:

. . . a greater proportion of female physicians require psychiatric care than medical or surgical care compared to their male counterparts,

. . . female physicians are less reluctant to seek psychiatric care than their male counterparts,

. . . female physicians are more reluctant to seek out surgical or medical care than their male counterparts,

. . . a smaller proportion of female physicians requires surgical or medical care compared to their male counterparts.

These investigations are beyond the scope of this study.

Physician-patients' chief complaints. This study demonstrates fairly obvious differences in the nature of physician-patients' chief complaints as perceived by surgeons, internists, and psychiatrists. As might be anticipated, physician-patient chief complaints reported by surgeons were well-defined within six disorder categories: cardiovascular, genitourinary, gastrointestinal, ear-nose-throat, neurologic, and hernia. While chief complaints of cardiovascular problems and physical examination were most common among the sampled internists, disorders of nearly all organ systems as well as functional problems such as depression and drug/alcohol abuse were reported. Perhaps most noteworthy is the observation that the majority of psychiatrists described depression as a physician-patient chief complaint.

Diagnosing physician-patients. Diagnoses made by surgeons closely paralleled their physician-patients' chief complaints. The largest concentrations clustered around respiratory, neurologic, genitourinary, and cardiovascular categories, more than half of 147.

Reflecting the varied nature of chief complaints offered by physician-patients to their internists, diagnoses reported by internists included disorders of many organ systems. However, the largest concentrations of physician-patients fell into two diagnostic categories: cardiovascular problems (25 of 67 diagnoses) and gastrointestinal problems (10 of 67 diagnoses).

Of 74 physician-patients diagnosed by psychiatrists, 27 (just over one-third) were found to be experiencing depression. Substance abuse was next most commonly diagnosed (17 out of 74 diagnoses) followed by anxiety (12 of 74) and personality disorder (8 of 74). Interestingly, three cases of manic-depressive illness, two cases of psychosexual disorder, and one case of schizophrenia were reported among psychiatrists' diagnoses.

"Our project, which focused on physician morbidity, is intended to provide background information which may be helpful to those working towards a preventive approach to physician impairment."

SUMMARY. Beyond our data are many more questions on this subject than answers. These questions revolve around such issues as: How does a physician-patient share in the responsibility for his/her own treatment? How does the treating physician overcome his own feeling of incompetence or competition or frustration in caring for a colleague? How does a physician assume the sick role when that's what he's been trained to fight? Does the physician never really become a patient? Do physicians mostly seek the competent physician for their illness, or do they turn to friends, or to colleagues they don't respect in an effort to maintain security in the unknown?[4] Our project, which focused on physician morbidity, is intended to provide background information which may be useful to those working towards a preventive approach to physician impairment.

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3 oz. canned pink salmon
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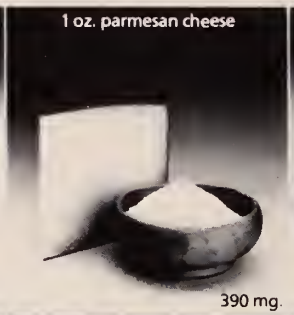
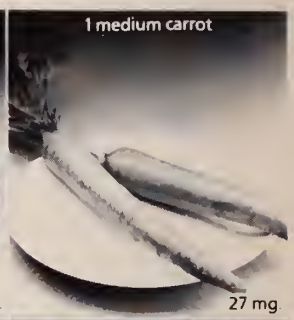
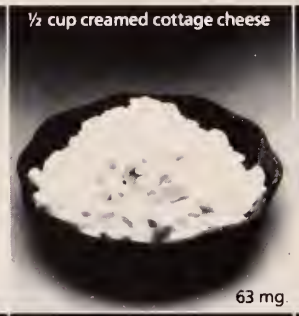
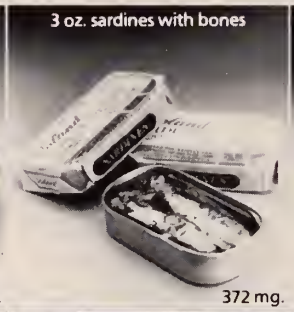

1 oz. parmesan cheese
390 mg.

½ cup cooked dried beans
35-48 mg.


1 medium carrot
27 mg.

1 medium orange
60 mg


½ cup creamed cottage cheese
63 mg.


3 oz. sardines with bones
372 mg.

1 cup fruit flavored yogurt
345 mg.

1 oz. almonds
67 mg.

1 oz. cheddar cheese
204 mg

½ cup cooked broccoli
68 mg.

1 cup milk
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168 mg.

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The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

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Please see following page for Brief Summary.

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Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone

TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions Usage with Alcohol* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C* Should be given to pregnant women only if clearly needed. *Labor and Delivery* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers* Caution should be exercised when administered to a nursing woman. *Pediatric Use* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope. *Respiratory* Rarely, respiratory depression. *CNS Acute CNS Manifestations* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic* Visual blurring and focusing difficulty. *Hematologic* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

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SMS Board reaffirms its position: Don't drop CME requirement

The SMS Board of Directors reaffirmed its opposition to dropping mandatory continuing education for physicians at its February 2 meeting in Madison. Department of Regulation and Licensing Secretary Barbara Nichols and Ronald M Sommer appeared before the Board to discuss the agency's recent recommendation to abolish continuing education for physicians and other professionals.

Ms Nichols told the Board that "invoking the police power of the state to condone professionalism is an inappropriate way for the state to use its limited resources. This (CE process) squarely belongs within the professions," she said.

Mr Sommer, who authored the Department's report on continuing education, said that mandatory continuing education was "perpetrating a fraud upon the public." The report concluded that continuing education misleads the consumer by giving the false impression that those who meet the requirements are competent to practice.

While Mr Sommer said he was "convinced that there is no way to truly assure the public of the competency of professionals," he believes "there are alternatives to CME to move us closer to competency." These alternatives include: (1) periodic retesting at the "minimum competency level," (2) a voluntary recertification program at the state level, and (3) an "extraordinarily tight" system of CME which requires physicians to take needs assessment tests and then take courses to correct identified deficiencies.

Several SMS Board members pointed out the problems associated with defining competency and said that the defrauding-the-public argument about continuing education could be made about licensing itself. Any certification process implies competence, the Board maintained.

In other action February 2, the SMS Board of Directors voted to:

- Support the Medical Examining Board in its effort to fight a rule recently adopted by the Chiropractic Examining Board allowing chiropractors to draw blood.
- Seek a $1 million "cap" on awards for medical malpractice in Wisconsin, as opposed to a cap on the Patients Compensation Fund liability.
- Approve the appointment of the following physicians to an SMS Committee on Membership: Timothy T Flaherty, MD, Neenah; Allen O Tuftee, MD, Beloit, and Richard D Fritz, MD, Milwaukee.
- Approve a 1985 State Medical Society budget of $2,142,700; subject to House of Delegates review.
- Recommend to the House of Delegates, which sets dues in April, that there be no dues increase in 1986.
- Accept a report from SMS Services, Inc that it netted a $49,000 profit in 1984.
- Endorse a "Drug Abuse Cocaine Symposium" to be held on April 18 and 19 in Milwaukee. The symposium is being sponsored by the Wisconsin Institute on Drug Abuse of the Tellurian Community and the American Medical Association.
- Cosponsor a second "Citizen's Conference on Alcohol and Drug Abuse" scheduled for October 3 and 4, 1985.
- Allow a student from each medical school to attend Board meetings as nonvoting members.
- Appoint Doctors John K Scott, MD, Madison, SMS president-elect; Jack Westman, MD, Madison, and a representative from the Society's Subcommittee on the Public Health Consequences of Nuclear Armaments, to represent the Society in a special discussion on the health consequence of nuclear war on February 11 with Soviet physicians touring the US. (See separate story elsewhere in this issue.)
- Support a VISTA project application of the Coalition of Wisconsin Aging Groups aimed at addressing the cost of healthcare and lack of housing alternatives for low-income elderly persons.
- Approve a public relations proposal for the Society, entitled "REACH-Resource for Education and Awareness of Community Health: A Program to Improve the Public Image of Physicians." This proposal will be the subject of an "SMS Update" report and mailed to all SMS physicians.
- Sponsor a physician conference on child abuse scheduled tentatively for May 18 in Madison.
- Appoint David G DeCock, MD, Madison, to the Regional Advisory Committee of the UW Hospital and Clinics' Med Flight service (a helicopter emergency transport service).
- Appointed Susan Turney, MD, Marshfield, as the Internal Medicine Section representative on the Commission on Governmental Affairs. ■

Mark your calendar for SMS Annual Meeting April 25–27 in La Crosse

The State Medical Society of Wisconsin will hold its 1985 Annual Meeting on April 25-27 in La Crosse. The La Crosse Center is the site for House of Delegates and Scientific Sessions and the Radisson La Crosse is the convention hotel.

"Cost Effective Care of the Geriatric Population" is the theme for several panels featured during the meeting. Panels will be held on: "Drugs and the Geriatric Population, A Masquerade"—Thursday afternoon, April 25; "Economic Considerations in Rationing of Geriatric Care"—Friday morning, April 26; "The Ethics of Rationing Geriatric Care"—Friday afternoon, April 26; and "Osteoporosis: Its Prevention and Treatment"—Saturday morning, April 27.

The first session of the House of Delegates will begin at 9:00 am Thursday, April 25, with second and third sessions scheduled for 1:45 pm Friday, April 27.

A summary of the resolutions to be taken up by the House of Delegates will appear in the April issue of *WMJ*. [Physicians are urged to contact their county society officers and delegates to express their views. A list of county society presidents and secretaries appeared in the February issue. A list of delegates and alternates appears elsewhere in this issue.]

Thursday evening, April 25, SMS President Timothy Flaherty, MD and Auxiliary President Roberta Baldwin invite physicians and spouses to attend the Presidents' Reception and Dinner. Musical entertainment will be provided.

The Reverend Gary Turner, Episcopal Diocese of Eau Claire, will speak at the Medicine and Religion Breakfast on Friday, April 26, at 7:00 am. Reverend Turner will discuss a "Native American View of Medicine and Religion."

WISPAC will once again sponsor the Socioeconomic Luncheon featuring a prominent speaker from political circles on Friday, April 26, at 11:45 am.

Scientific programs from the major specialties will be presented throughout the day on Saturday, April 27.

All Society physicians are strongly encouraged to attend the SMS Annual Meeting and take part in both the business and scientific matters of the Society. The Annual Meeting Program was mailed to members in early March. ■

Medical Society asks broadcasters to help fight alcohol abuse

The link between alcohol abuse and advertising and current efforts to ban beer and wine advertising on radio and television was debated among representatives of medicine, broadcasting, and the beer industry February 12 in Madison.

Conrad Andringa, MD, a member of the State Medical Society's Committee on School Health, told members of the Wisconsin Broadcasters Association that he saw alcohol on a different level than they did.

"As a physician I see the end result of alcohol. Alcohol is the number three killer in the US today and 20 percent of all admissions to Madison General Hospital are alcohol related," he said.

Doctor Andringa illustrated the pervasiveness of the problem by pointing out that in 1981 Wisconsin consumed 11 million gallons of liquor and 164 million gallons of beer.

He said that alcohol is the number one abused drug in the US today. "I'm not so naive as to think that we can ban it," he said. "Rather, we should concentrate on what we can do to prevent alcohol from being misused."

He urged the broadcasters to do more than produce and air public service announcements on preventing alcohol abuse. "We should look at improving the alcohol ads," he said. According to Doctor Andringa, this means changing the way alcohol is promoted and by whom.

"Perhaps we could add a tag to the end of commercials urging people not to misuse this drug," he said. "We (medicine, broadcasting, and the beer industry) have a chance to do something positive for a lot of people who go through tragedy because of alcohol."

Also speaking on the panel with Doctor Andringa was John Summers, executive vice president of government relations of the National Association of Broadcasters, and Thomas Reed, government affairs manager for Miller Brewing Company.

Mr Reed agreed with Doctor Andringa that there was a tremendous alcohol abuse problem in this country, but said answers that many legislators have proposed such as banning advertising of beer and wine and raising the drinking age will do little to solve the problem.

Mr Reed conceded that much of the pressure the beer manufactur-

ers are facing today from the public to do something about their advertising is because of their reluctance to push alcohol moderation in the past.

He said that the major brewers have developed educational programs for the schools and civic groups stressing that "moderate consumption is an individual responsibility and if you have a problem, please seek help."

John Summers of the National Broadcasters Association stated that the evidence has turned up no firm link between alcohol abuse and advertising. He said that his association is confident that they have turned around "Project Smart" movement to ban beer and wine advertising over the airwaves.

He still fears that someone on Capitol Hill will tack an ad ban proposal onto a Congressional spending bill.

"One part of our act that we really have to clean up," according to Summers, "is our marketing approaches for beer such as 100 free minutes of drinking in taverns, sponsoring beer buses, etc."

"We've started this, but we're not finished and this is where we are most vulnerable." ■

SMS Task Force on Medical Care to meet Mar 22

The 1984 SMS Task Force on Medical Care was to meet at Society offices in Madison March 22 to review preliminary reports of the five work groups. These work groups focus on the subjects of Reimbursement and Delivery, Quality Care, Competition, Physician-Hospital Relations, and Physician Contracting. The Task Force and its component work groups have been meeting over the past several months to research, analyze, and offer policy recommendations and strategies for the future. The Task Force will be reporting to the SMS House of Delegates in April. The Task Force is assigned to the SMS Physicians Alliance Division/Brian Jensen, director. ■

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_____

State Medical Society of Wisconsin

Program Schedule—Annual Meeting, Apr 25–26–27, 1985, La Crosse

THURSDAY, APRIL 25

Section Delegates Caucus
Taebel Room (LC), 8:00 am

District 1 Caucus
Erwin Room (LC), 8:00 am

Registration H/D
Flaherty/Treffert Room (LC), 8:00 am

House of Delegates First Session
Flaherty/Treffert Room (LC), 9:00 am

Drugs & The Geriatric Population Luncheon/Program
Taebel Room (LC), 12:00–1:30 pm

Reference Committee Meetings
Mezzanine Level, Radisson, 1:00 pm

Presidents' Reception and Dinner
Ballroom, Radisson, 7:00 pm

FRIDAY, APRIL 26

Medicine & Religion Breakfast
Ballroom, Radisson, 7:00 am

Economic Considerations in Rationing of Geriatric Care, Panel I
Scott Room (LC), 9:00 am–11:30 am

The Ethics of Rationing of Geriatric Care, Panel II
Scott Room (LC), 2:00 pm–4:00 pm

Wisconsin Academy of Ophthalmology BOD Meeting
Erwin Room (LC), 11:00 am

District 1 Caucus
Scott Room (LC), 11:30 am

Socioeconomic/WISPAC Luncheon
Radisson, 11:45 am

Physical Medicine & Rehabilitation Luncheon & Program
Taebel Room (LC), 12:15 pm

Plastic Surgery Program
Directors Room (LC), 1:00 pm

Registration H/D
Flaherty/Treffert Room (LC), 1:00 pm

Ophthalmology Program
Erwin Room (LC), 1:30 pm

House of Delegates Second & Third Sessions
Flaherty/Treffert Room (LC), 1:45 pm

Key: La Crosse Center (LC)

Family Physicians Program
Scott Room (LC), 2:00 pm

Wisconsin Society of Pathologists BOD Dinner/Meeting
Minnesota Room, Radisson, 6:00 pm

Wisconsin Surgical Society Council Dinner
Iowa Room, Radisson, 5:30 pm

Wisconsin Society of Internal Medicine Dinner
Ballroom, Radisson, 6:30 pm

Past Presidents' Reception and Dinner
Illinois Room, Radisson, 6:00 pm

SATURDAY, APRIL 27

Surgery Program & Luncheon
St Francis Medical Center
7:45 am–1:00 pm

Surgery Program
Scott Room (LC), 1:30 pm

Surgery Evening Program and Dinner
Country Club, 600 Losey Blvd South, 6:30 pm (by invitation only)

SMS Board of Directors Breakfast Meeting
Illinois Room, Radisson, 8:00 am

Osteoporosis: Its Prevention and Treatment, Panel III
Scott Room (LC), 8:00 am–12:00 noon

Internal Medicine Program
Scott Room (LC), 8:00 am

Wisconsin Society of Internal Medicine Council
Minnesota B Room, Radisson, 12:30 pm

Preventive Medicine Program
Scott Room (LC), 8:00 am

Otolaryngology Program
Treffert Room (LC), 8:30 am

Pathology Program
Flaherty Room (LC), 9:00 am

Wisconsin Society of Pathologists Reception and Dinner
La Crosse Club, 5:00–9:00 pm

Dermatology Program
Taebel Room (LC), 9:00 am–1:00 pm
Gundersen Clinic, 1:00 pm–5:00 pm

Anesthesiology Luncheon and Program
Erwin Room (LC), 12:15 pm

Radiation Oncology Luncheon and Program
Iowa Room, Radisson, 12:15 pm

Psychiatry Luncheon and Program
Zielke Room (LC), 12:15 pm

Emergency Medicine Program
Directors Room (LC), 1:00 pm

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	Patrick R Walsh	
	Jeffrey M Weber	
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	D MacLean Willson	
	Donald A Wollheim	
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	Raymond C Zastrow	
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	Carl F Myers	Dai Kap Kim
	Marvin G Parker	Kevin W McCabe
	Raymond E Skupniewicz	Jerome J Veranth
WALWORTH	Irwin J Bruhn	Rocco S Galgano
WASHINGTON	Charles S Geiger Jr	William J Listwan
	Michael C Reineck	Eric F Weber
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	Charles E Holmburg	Peter T Geiss
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	Robert B Gage	Paul F Dvorak
	William L Kopp	Norman M Jensen
	Richard D Lindgren	Robert A McDonald
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	Bernard F Micke	Kathryn P Nichol
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	Sandra L Osborn	William R Scheibel
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	Paul M Stiegler	Ronald D Wenger
	John D Wegenke	Paul A Wertsch
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	Marshall F Purdy	William P West
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	Robert A Keller	James R Pawlak
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EAU CLAIRE-DUNN-PEPIN	Daniel F Johnson	Verne A Sperry
	Thomas E Pederson	Peter H Ullrich
	Karl E Walter	Vacancy
	James E Willard	Vacancy
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POLK	John O Simenstad	William W Young
RUSK	Howard T Chatterton	Douglas M DeLong
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DOUGLAS	K G Ramesh	Clarence M Scott
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Dermatology	Joel E Taxman	Nyles R Eskritt
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Family Physicians	Robert S Viel	Vacancy
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Ophthalmology	M Thomas Chemotti	Vacancy
Orthopedics	Paul A Jacobs	David D Mellencamp
Otolaryngology	Glenn M Seager	Thomas W Grossman
Pathology	Edward A Burg Jr	Jay F Schamberg
Pediatrics	Ferrin C Holmes	Vacancy
Physical Medicine & Rehabilitation	Sridhar V Vasudevan	William J LaJoie
Plastic Surgery	John E Hamacher	Vacancy
Preventive Medicine	Vacancy	Paul R Ebling
Psychiatry	Rudolf W Link	Vacancy
Radiology	Marcia J S Richards	Vacancy
Resident Physicians	Vacancy	Vacancy
Surgery	P Richard Sholl	Louis C Bernhardt
Urology	Stuart W Fine	Charles W Troup

Health education radio series is renewed

DANE: Dane County Medical Society members have been asked to assist in preparing one-minute features on health topics for presentation on a Madison radio station. The Dane County Medical Society Board of Trustees heartily endorsed revival of this program of several years ago. Under its new call letters WTDY Radio—1480 (formerly WISM—AM) has changed its programming format to include more information directed to an adult audience. Part of this change includes broadcasting one- to two-minute features on various health topics five days per week. Under the renewed program a different DCMS member will prepare five features, one to two minutes in length, suitable to his/her specialty. Program credits will identify the individual physician and the Dane County Medical Society. Further information may be obtained by contacting the Dane County Medical Society, PO Box 1109, Madison, WI 53701; or calling (608) 257-6781.—*Don A Bukstein, MD,** Secretary

SHEBOYGAN: Robert A Helminiak, MD,* recently was elected president of the Sheboygan County Medical Society. He will serve through December 1986. Also elected to serve for two years are Christopher L Larson, MD,* president-elect; and Robert J Scott, MD,* secretary. —*Robert J Scott, MD,** Secretary

BROWN: Raymond M Waldkirch, MD,* Green Bay, was honored for his 50 years of practice by the Brown County Medical Society at its January meeting and by the State Medical Society. Both societies presented him with a plaque recognizing him for distinguished service for fifty years as a member of the Brown County Medical Society and the State Medical Society, 1934-1984. County society President James R Mattson, MD* conducted the meeting and Lyle H Edelblute, MD,* chairman of the Awards Committee, gave a brief biographical sketch of Doctor Waldkirch who responded with a few comments regarding the changes in the practice of medicine during his 50 years of service.

Doctor and Mrs Waldkirch

The remainder of the evening revolved around the annual auction sponsored by the Brown CMS's Auxiliary to raise funds for the local scholarship program. One hundred and fifty members and their spouses attended the meeting.—*Stephen D Hathway, MD,** Secretary ■

SMS dues due by May 15

In April members will receive their final dues statement for membership in the State Medical Society. Regular member dues of $455 must be paid in full no later than May 15, 1985 to continue as a member, as well as other member classifications with varying dues amounts. The Society's official membership roster, listing all paid members of record at SMS headquarters as of May 31, 1985, will be used in the preparation of the *Wisconsin Medical Journal's* Membership Directory to be published in the July issue. To ensure a complete and accurate roster of current members and those planning to join for the first time are urged to make their final payments well in advance of the May 15 deadline to allow for administrative functions to be completed by the May 31 cutoff date. ■

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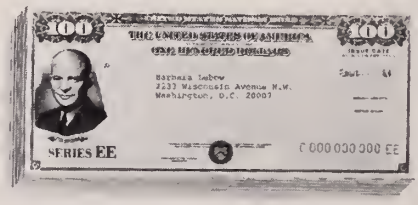

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Governor delivers 1985-87 budget; many healthcare items included

On January 29 Governor Earl formally presented to the Legislature his 1985-87 budget which contained a number of healthcare items. They include:

• A 3.5% increase in Medicaid rates is proposed for each year of the biennium. Additionally, coverage of several Medicaid services (drugs, certain dental procedures, ambulatory services for children) is restored.

• The State proposes to subsidize the enrollment of low-income Medicare beneficiaries in HMOs. Under the proposal, persons with income less than 140% of the poverty level would be eligible, in up to four pilot areas, to have the State pay all or a portion of the cost of HMO enrollment. Approximately $500,000 is allocated to pay for these HMO premiums (in addition to Medicare reimbursements) between January 1, 1986 and June 30, 1987.

SMS has expressed its concern that this proposal, as it now stands, subsidizes HMOs instead of subsidizing low-income elderly. Funding designed to relieve the burden of healthcare costs on low-income elderly consumers should not force those consumers to give up their choice of healthcare provider. SMS believes subsidies made directly to the client, to be used to offset healthcare costs, would be preferable to subsidies only to HMOs.

• Under the Governor's budget bill, the mandated insurance coverage for mental health, alcoholism, and drug abuse would be substantially modified. Required *inpatient* coverage would be reduced from 30 days to the lesser of $6,300 or 25 days, with a 10% copayment by the recipient. *Outpatient* coverage requirements would be increased from $500 to $1,000, with a 10% copayment; also, a requirement is added for $1,000 worth of coverage for *day treatment/partial hospitalization,* with a 10% copayment. Total annual coverage (inpatient, outpatient, and day treatment) would not have to exceed $7,000.

The State Medical Society has objected to these proposed changes. The Society is on record in opposition to mandated insurance benefits and further believes that the proposed changes would make a bad mandate worse.

• An expansion of the 51.42/ Medicaid "gatekeeper" program is proposed. Presently under this program, all mental health, alcoholism, or drug abuse care for Medicaid recipients between ages 22-64 years *must* be approved by the county 51.42 board. The board

1983 Health spending

The nation's 1983 health expenditures were $355 billion—an average of $1,459 per person—Health Care Financing Review has reported. This is 10.8% of the GNP. Of the total $313 billion was for personal healthcare.

In its detailed annual review of data compiled by the Health Care Financing Administration, the publication said that *healthcare cost outlays rose 10.3% between 1982 and 1983.*

Here are the funding sources for the 1983 healthcare dollar (which totaled $313 billion of the $355 billion spent for health in the US in 1983):

Private health insurance	31 cents
Direct patient payments	24 cents
Medicare	17 cents
State, local governments	8 cents
Other federal government programs	7 cents
Federal Medicaid	5 cents
State Medicaid	5 cents
Philanthropy	3 cents

Here's where the money goes:

Hospital care	41 cents
Physicians' services	19 cents
Nursing home care	8 cents
Other services, goods	20 cents
Research, construction, etc.	12 cents

The 29-page article, "National Health Expenditures, 1983," by Robert M Gibson, et al, appeared in the Winter, 1984 volume of Health Care Financing Review, which has just been published. Physicians who wish reprints may direct their request to M Carol Pearson, Division of National Cost Estimates, Room 2-C-7, Meadows East Building, 6325 Security Boulevard, Baltimore, Maryland 21207. ■

also pays a share of the Medicaid cost, usually 10% or 20%. With the proposed expansion, mental health or AODA services for *all* Medicaid recipients would require 51.42 board approval, with the board paying the entire state share (42%) for inpatient care to persons aged 22-64 and paying 20% for all other services and persons.

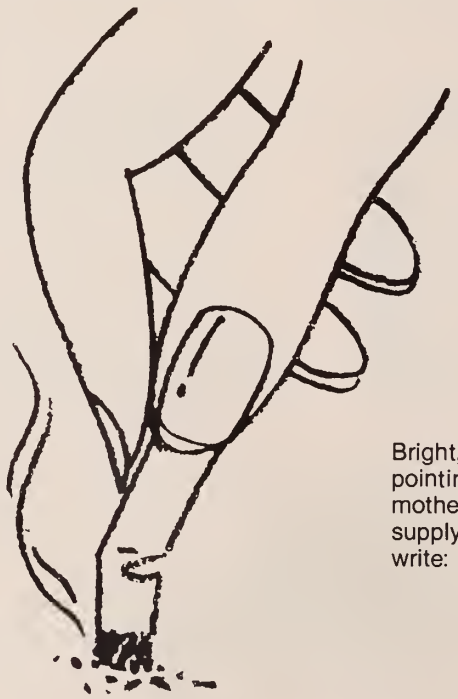
The gatekeeper program, in its current form, has been problematic with sometimes arbitrary or inappropriate denials of service by the local 51.42 board. The program puts the county in the difficult position of having a strong financial incentive to disapprove requests for care or having to pay out of limited funds for care previously funded through Medicaid. The State Medical Society has objected to any expansion of this already problematic program.

In addition to these issues SMS expects strong efforts to be made seeking inclusion of mandatory chiropractic insurance coverage, mandatory open-panel participation in HMOs and PPOs for dentists, optometrists, podiatrists, and others, and repeal of the Capital Expenditure Review Program.

The budget bill has now gone to the Joint Finance Committee which will be working on it for the next several months.

SMS lobbyists Don Lord and Terry Hottenroth of the Society's Physicians Alliance Division will be following all of the healthcare-related issues as well as other issues of particular concern to physicians as citizens. ■

1985 ANNUAL MEETING: APRIL 25–27, LA CROSSE



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Of course, we don't expect you to send patients to our medical campus just because we built a few guest rooms. Our reputation as a regional referral center is based on clinical excellence, the full range of specialties, alternative care programs and competitive prices.
Our perinatal, cardiovascular and rehabilitation programs have earned [illegible] recognition.
When you need to refer patients for tertiary care, you can trust us. We're as concerned about their total well-being as you are.
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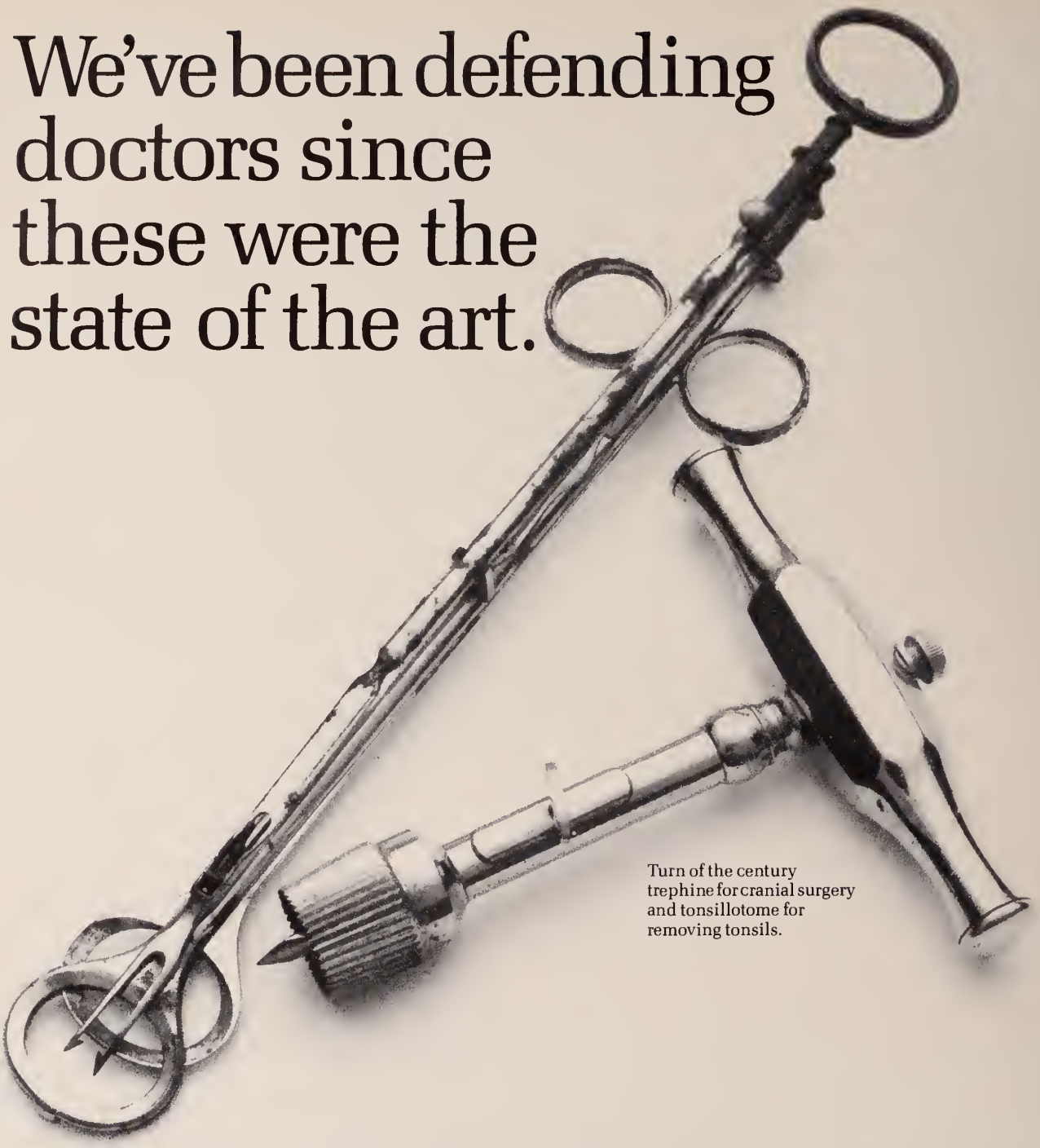

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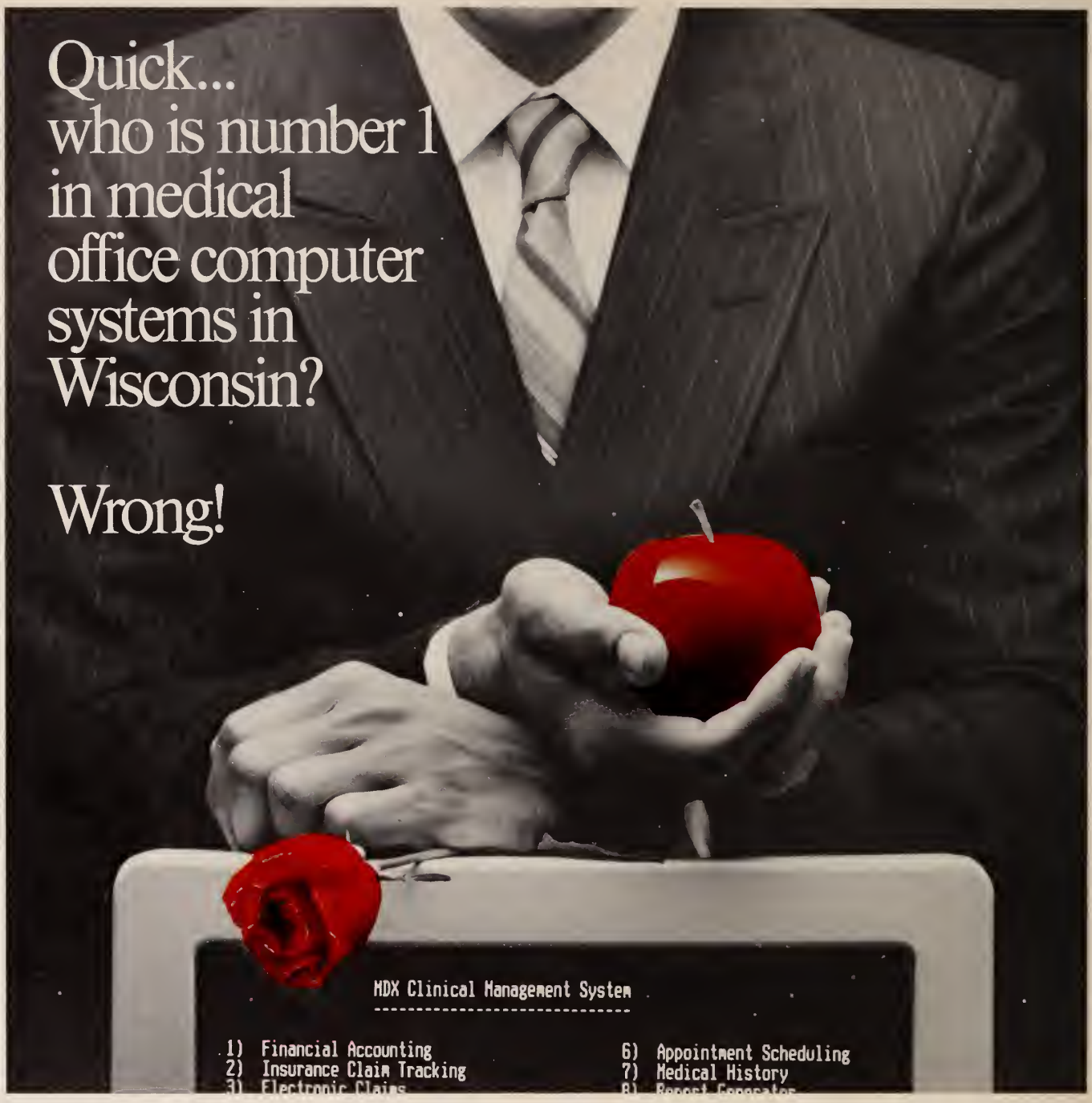

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PHYSICIANS EXCHANGE

Primary Care Physician position is available at the University of Minnesota Boynton Health Service, a comprehensive outpatient facility serving a population of 66,000 students, faculty and staff on the Twin Cities campus. Thirty-five full-time equivalent physicians, 5 nurse practitioners, and 15 registered nurses are on staff. The physician is case manager for a set of established patients. Specialty consultations available on-site. Continuing medical education, quality assurance review, and clinic accreditation provided. The position requires an MD degree, Board certification or eligibility in a primary care specialty, and license to practice in Minnesota. Must have a broad range of medical abilities and relate well to an educated, health-conscious clientele. Experience or interest desirable in public health aspects of infectious disease control and group practice. Salary competitive and commensurate with training and experience. Regular hours and excellent fringe benefits including paid professional liability insurance. Position available July 1, 1985. Please send resume by May 10, 1985 to Donald Severson, MD, Chair, Physician Search Committee, University of Minnesota, Boynton Health Service, 410 Church Street SE, Minneapolis, Minn 55455. For further information, call Dr Severson at (612) 376-5293. The University of Minnesota is an equal opportunity educator and employer and specifically invites and encourages applications from women and minorities. 3/85

Internal Medicine. Join multispecialty group of nine physicians in Sturgeon Bay, Wisconsin. Primary care, consultations. Modern 110-bed hospital. Attractive financial package. Live in beautiful Door County. Charles Nelson, Fox Hill Associates, 250 Regency Court, Waukesha, Wisconsin 53186; ph 414/785-6500 collect. p2-3/85

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; e.g., copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

General Surgeon. Board certified or eligible to replace retiring surgeon in 16-physician multispecialty group practice (2 surgeons, 2 Ob/Gyn, 6 internists and 6 pediatricians). Two-year salary guarantee with full partnership available at beginning of third year. Send CV to T E Flood, Administrator, Beaumont Clinic, Ltd, 1821 So Webster Ave, Green Bay, WI 54301. p2-4/85

Orthopedic Surgeon. An excellent opportunity is available for two orthopedic surgeons to join a progressive Medical Group in Central Minnesota. The community serves a population base of 225,000 individuals and is an excellent base for an orthopedic surgeon. St Cloud, Minnesota is the hub of the State and is home to three major colleges. It is geographically located to provide quick access to the Metropolitan-Twin Cities area. The St Cloud community has a 500-bed hospital with all the latest medical and technological advancements to assist the practicing orthopedic surgeon. If interested in this excellent opportunity, please call collect either Dr LaRue Dahlquist, President, and/or Daryl Mathews, Administrator, at 612/251-8181 and/or send curriculum vitae to St Cloud Medical Group, 1301 West St Germain Street, St Cloud, Minnesota 56301. 2-5/85

Family Physician and Internist, Pediatrician, OB/GYN, Board eligible/certified. Full or part-time, to join a busy, established group of physicians in Milwaukee. Attractive income. Send curriculum vitae to PO Box 17366, Milwaukee, WI 53217. 2-7/85

Academic Internist to join expanding dynamic young Ambulatory Care Group at the Milwaukee Regional Medical Center. Responsibilities to include: primary patient care, resident/physician education, and employee health. Opportunities for program development, administration, research, and advancement in clinical faculty track. Send inquiries to Kenneth E Smith, MD, Director, Primary Care Clinic, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Equal opportunity/affirmative action employer M/F/H. 1-3/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

Wanted—Qualified physician to practice emergency medicine in southeastern Wisconsin. Our group is small and flexible. Salary is negotiable. If interested, send CV to Associated Emergency Room Physicians, SC, 1131 Sherwood Lane, Caledonia, Wis 53108; ph 414/835-4489. p1-3/85

Internal Medicine—Board certified or eligible, to join 17-physician multispecialty clinic with 7-physician internal medicine department. Located in beautiful Wisconsin lakeshore community of 35,000. Competitive salary, complete fringe benefits, generous vacation time. Send CV to: Administrator, Manitowoc Clinic, SC, PO Box 3008, Manitowoc, WI 54220. 1-5/85

Madison, Wisconsin. Experienced physician for ambulatory care center. Medic-East, first and only independent ACC in Madison. Now well established. Located in heart of Eastside of Madison. Applicants BC/BE demonstrated experience in primary care, well-developed communication skills. Competitive salary, excellent benefits, attractive practice setting. Contact David A Goodman, MD, Medic-East, 2810 E Washington, Madison, WI 53704; ph 608/244-1213. 1tfn/85

Internists—BC/BE Internist needed to join five general internists in multispecialty group practice in north-central Wisconsin. Competitive salary and benefits. General medicine training required. Cosmopolitan community and excellent recreational area. Send CV to D K Augenbaugh, MD, 2727 Plaza Dr, Wausau, WI 54401; or phone 715/847-3328. 1tfn/85

Family Practice physician MD or DO Board eligible or certified. Contact Leon Gilman, 4957 West Fond du Lac Ave, Milwaukee, Wi 53216 or call 414/871-7900. 1-3/85

PHYSICIANS EXCHANGE

continued

Family Practice position available at Stanley, Wisconsin. This physician would join an existing family practitioner in a hospital-affiliated satellite center of Marshfield Clinic, a major multispecialty referral center. The ideal candidate would enjoy practicing a full medical spectrum including obstetrics and pediatrics, would enjoy working in a modern clinic facility that is physically attached to a 41-bed community hospital, and would enjoy living in a small rural community only 30 minutes from Wisconsin's fastest growing metropolitan area that contains a major University of Wisconsin campus. This opportunity offers a $63 thousand starting salary plus an extensive fringe benefit program. Please send curriculum vitae with first letter to: John P Folz, Assistant Director, 1000 North Oak, Marshfield, Wisconsin 54449. 1/85;3/85

Family Practitioner, General Surgeon, Neurologist and Pediatrician/Central Wisconsin. Excellent opportunity for Board certified/eligible physician to join 26-physician multispecialty group. 180-bed modern hospital. Plentiful recreational, cultural, and educational opportunities. Unique, attractive financial arrangements. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481; ph 715/344-4120. 1tfn/85

Obstetrician-Gynecologist, Board certified or eligible, to join 17-physician multispecialty clinic with two physician OB/GYN department. Located in a beautiful Wisconsin lakeshore community of 35,000. Competitive salary, complete fringe benefits, generous vacation time. Send CV to: Administrator, Manitowoc Clinic, SC, PO Box 3008, Manitowoc, WI 54220. 6-12/84;1-5/85

Orthopedic Surgery. Nicolet Clinic, SC, Neenah, Wisconsin, is seeking a third orthopedic surgeon to join a busy, expanding department. Recent clinic expansion has provided excellent orthopedic facilities, and is located close to Theda Clark Regional Medical Center, a modern full-service hospital, fully-equipped for all orthopedic inpatient services. Neenah is centrally located in the beautiful Fox River Valley of Eastern Wisconsin. Excellent cultural, educational, and recreational opportunities available. Contact Roger A Rathert, MD, Nicolet Clinic, SC, 411 Lincoln Street, Neenah, WI 54956. 3/85

14 MD multispecialty clinic wishes to add third OB/GYN 7/1/85. Three progressive hospitals (regional referral center for Maternal High Risk); ultrasound, office cytoscopy, colposcopy, laser, hysteroscopy, etc; no abortions. Competitive salary and benefits leading to partnership in two years. Excellent family community with multiple recreational and cultural activities available. Send CV to T E Flood, Administrator, Beaumont Clinic, Ltd, 1821 S Webster Ave, Green Bay, WI 54301. p12/84;1-3/85

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 10-12/84;1-3/85

Family Practitioners needed to staff satellite locations and Urgent Care Centers located in Northeast Wisconsin. Please send CV to Dept 554 in care of the Journal. 2-5/85

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone: 608/263-4095 7/84;6/85

St Francis Medical Center—La Crosse: Full-time Family Practice faculty position with opportunity for teaching and practice in the St Francis/Mayo Family Practice Residency with Mayo Clinic faculty appointment. Currently, four full-time family physicians and 13 residents in clinic and hospital. Send inquiries to: Ted Thompson, MD, Program Director, St Francis/Mayo Family Practice Residency, 700 West Avenue South, La Crosse, Wisconsin 54601; ph 608/785-0940. 2-3/85

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

The Racine Medical Clinic, a progressive cluster corporation of 31 physicians is currently seeking an Obstetrician/Gynecologist physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 12tfn/84

The Racine Medical Clinic, a progressive cluster corporation of 31 physicians is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 12tfn/84

Family Practice physician needed to join five family practitioners and a general surgeon. Immediate opportunity in west central Wisconsin near La Crosse. $45,000 first year guarantee plus incentive. Excellent recreational area. Community Hospital. Send CV to: Jerrold L Kamp, Administrator, PO Box 250, Sparta, WI 54656; or phone 608/269-6731. 6tfn/84

Immediate opportunities for qualified physicians who possess excellent clinical and communication skills to join long-standing group of Emergency Physicians. Positions available in a popular Wisconsin area bordering Illinois. If interested, send resume to Barbara Wilczynski, Medical Emergency, Service Associates (MESA), SC, 15 S McHenry Road, Suite 2, Buffalo Grove, IL 60090 or call collect 312/459-7304. 6tfn/83

Wisconsin-BC/BE Pediatrician to assume an established position of a pediatrician leaving. Join a three-man pediatric department. Call or write: David L Lawrence, MD, 92 E Division St, Fond du Lac, WI 54935; ph 414/921-0560. p3-8/85

PHYSICIANS EXCHANGE

continued

Wanted: Young Family Practitioner to join a ten-physician group in western Wisconsin. Contact R M Hammer, MD, River Falls, Wisconsin 54022; ph 612/436-8809 or 715/425-6701. 8tfn/84

Internist, with or without subspecialty, and an OB/GYN needed (Board certified or eligible) to practice in conjunction with a 7-member Internal Medicine Department and a 5-member OB/GYN Department in a 24-member multispecialty group. The Internal Medicine Department currently has subspecialties in gastroenterology, pulmonary medicine, and cardiology. The Group is located in Southeastern Wisconsin in a city of 100,000, between two major metropolitan areas of greater than one million. Estimated service area is approximately 200,000. If interested, please send CV to Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential and additional information will be sent. 7tfn/84

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

MEDICAL FACILITIES

Family Practice for sale in Milwaukee. Ideal starter or satellite office. Excellent patient goodwill. Fully equipped and furnished three examining rooms, waiting room, and office. Approximately 900 sq ft. Contact Greg Rodenbeck, DDS, 1200 E Oklahoma Ave, Milwaukee, Wis 53207; 414/481-8111. g10tfn/84

Physicians: US Air Force Medical Corps is currently accepting applicants for physicians in the following specialties: Aerospace Medicine; Orthopedics; Ear, Nose, and Throat; Obstetrics/Gynecology; General Surgeons; Family Practitioners; Internal Medicine, and Pediatrics. For more information call: 414/258-2430. 2-4/85

Medical-Dental Facility. Share desirable clinic and reception area, front office personnel. Ample parking. Westside. Call 608/238-6529. 3/85

Medical practice or equipment for sale in Milwaukee. Completely equipped, modern office with a modern x-ray machine. I am retiring. Please call 414/272-0250 or 414/962-9382 for an appointment. 3/85

Madison, West Side. Hilldale Professional Building. Deluxe office suites, 1200-1700 sq ft. Full service—undercover parking. Call Ralph at office 608/273-5800 or home 608/836-3586. 2tfn/85

MISCELLANEOUS

Will instruct physicians in the art of Hypnosis using their own medical facilities and patients. Thirty-five years experience. For information call 414/628-2839, John H De Werth, MD. p3/85

ANNOUNCEMENTS

Reye syndrome. Although the evidence linking aspirin and other salicylates with Reye syndrome is not conclusive, it would be prudent for parents to avoid giving aspirin or other medications containing salicylates to children with chickenpox or influenza-like illnesses, a report by the American Council on Science and Health states. Entitled "Reye Syndrome: Questions and Answers," the report may be obtained by sending a self-addressed, stamped (39 cents postage), business-size (#10) envelope to Reye Syndrome Report, ACSH, 47 Maple St, Summit, NJ 07901.

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Kodak Ektachem 55, 56, 57
Clinical Chemistry Products
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Microcomputers in Medicine 38
PBBS Equipment 14
Professionals Insurance Company, The 51
Roche Laboratories . . . . . 65, BC
Dalmane®
S & L Signal Company 15
Squibb & Sons, Inc, E R 19, 20, 21, 22
Velosef®
St Mary's Hill Hospital 9
United States Army Active 41
United States Army Air Force 43
United States Army Reserve 15
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Motrin®
Winthrop Breon Laboratories . . . 37, 38
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MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

APRIL or MAY 1985: Wisconsin Association of Medical Directors *Annual Meeting* (in conjunction with the County Homes Association), tentatively at Stevens Point. More definite details to come. g12/84

APRIL 19–20, 1985: Wisconsin Urological Society, Pfister Hotel, Milwaukee. g11tfn/84

MAY 2–3, 1985: *Introduction to Computers in the Medical Office,* Wisconsin Center, Madison. Course is designed for physicians who have interest in computer applications in the medical office, but little knowledge or experience upon which to base decisions. Focus is on the basics. AMA Category 1 and UW-Extension CEUs. Contact Dick Hansen, UW-Extension, Continuing Medical Education, Room 460 WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2853. 3/85

MAY 3, 1985: Wisconsin Orthopedic Society, American Club, Kohler. g2-4/85

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE tor listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

APRIL 17, 1985: *New aspects of pathogenesis and treatment in osteoarthritis,* at the Pioneer Inn, Oshkosh. Sponsored by Berlin Memorial Hospital and Pfizer Company. Speaker: Gary Gordon, MD, University of Pennsylvania. Accredited for 2 hours of CME Category I credit by AMA. Preregistration required: $20 includes program and dinner. Info: Linda Tieman, Berlin Memorial Hospital, phone 414/361-1313, ext 583. 3/85

MAY 9–11, 1985: Wisconsin Chapter, American Academy of Pediatrics, Pioneer Inn, Oshkosh. g11tfn/84

MAY 9–10, 1985: Methodist Hospital presents its 4th annual *Problem Solving in Emergency Care,* symposium, Madison. Physician, nurse, paramedic and EMT tracks. Tuition: $25–$150. Accreditation: 14 hours AMA Category I, App ACEP Category I. Contact: Mark Olsky, MD (Director), Methodist Hospital, 309 West Washington Ave, Madison, WI 53703; ph 608/251-2371, ext 3015. 3-4/85

State Medical Society of Wisconsin Dates and locations of ANNUAL MEETINGS 1985–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the La Crosse Convention Center.

1985—April 25–27
1986—April 17–19
1987—March 26–28
1988—April 28–30
1989—April 13–15
1990—April 26–28
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

MAY 16–18, 1985: *Diagnosis and Treatment of Thromboembolic Disease—1985.* Pfister Hotel, Milwaukee. Sponsored by University of Wisconsin-Milwaukee Clinical Campus, Mount Sinai Medical Center; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA Category 1, UW-Extension CEUs, 10 hours. Contact: Sarah Aslakson, UW-Extension CME, Room 465B, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 3/85

JUNE 3–8, 1985: *18th Annual Postgraduate Course in Gynecological Pathology, Endocrinology, and Maternal-Fetal Medicine,* presented by the Department of Gynecology and Obstetrics of the Medical College of Wisconsin. The course will be held at Olympia Resort, Oconomowoc. The six-day course includes an up-to-date review of endocrinology, maternal-fetal medicine, and cytogenetics in addition to a thorough resume of gynecologic pathology. Registration is limited. Course ap-

Wisconsin Specialty Society Meetings

- Wisconsin Urological Society, April 19–20, 1985, Pfister Hotel, Milwaukee
- Wisconsin Chapter: American Academy of Pediatrics, May 9–11, 1985, Pioneer Inn, Oshkosh
- Wisconsin Academy of Family Physicians, June 12–15, 1985, Americana Resort, Lake Geneva

* * *

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 25–27, 1985, La Crosse

- Wisconsin Society of Anesthesiologists
- Wisconsin Dermatological Society
- Wisconsin Chapter, American College of Emergency Physicians
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Internal Medicine
- Wisconsin Academy of Ophthalmology
- Wisconsin Otolaryngological Society
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine & Rehabilitation
- Wisconsin Society of Plastic Surgeons
- Wisconsin Society for Preventive Medicine
- Wisconsin Society of Radiation Oncologists
- Wisconsin Surgical Society

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

proved for 46 cognates, Formal Learning, by the American College of Obstetricians and Gynecologists and 46 credit hours, Category I, PRA/AMA. Eighty selected 35-mm slides will be available for purchase to all participants. Contact Richard F Mattingly, MD, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, WI 53226; tel 414/257-5560. p3-5/85

JUNE 12-15, 1985: *37th Annual Scientific Assembly of the Wisconsin Academy of Family Physicians,* Americana Resort Hotel, Lake Geneva, Wisconsin. Info: WAFP, 850 Elm Grove Road, Elm Grove, WI 53122; ph 414/784-3656. 12/84;1-5/85

JUNE 28-29, 1985: *Anxiety Disorders—Update 1985,* Wisconsin Center, Madison. Sponsored by School of Medicine, Department of Psychiatry, University of Wisconsin; Continuing Medical Education, University of Wisconsin-Extension. AMA Category I credit, University of Wisconsin-Extension CEUs. For more information contact: Ann Bailey, UW Extension, Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2854. 3/85

JUNE 28, 1985: *Microcomputers in Medicine,* Milwaukee. A one-day computer seminar and exposition for health care professionals. Topics include choosing a system; office practice management, computer-aided diagnosis. Fee: $50 before May 15 includes admission, lunch, and reception. Info: Micros in Medicine, MCW Libraries, 8701 Watertown Plank Rd, Milwaukee, WI 53226; ph 414/257-8323. g3-4/85

JULY 18-20, 1985: Wisconsin Society of Obstetrics & Gynecology, Olympia Resort, Oconomowoc. g2-6/85

SEPTEMBER 13-14, 1985: Wisconsin Surgical Society, Paper Valley Hotel & Conference Center, Appleton. g2-8/85

SEPTEMBER 13-15, 1985: Wisconsin Society of Anesthesiologists, American Club, Kohler. g2-8/85

OTHERS

MARCH 29, 1985 (Minnesota): *Sixth Annual Update in Occupational Medicine,* Radisson Plaza Hotel, St Paul. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3-85

APRIL 10-14, 1985 (Florida): *20th Annual Clinical Conference* at Longboat Key Club, Longboat Key. Sponsored by the Marquette-MCW Medical Alumni Association and the Medical College of Wisconsin. Info: Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226; ph 414/257-8367. 1-3/85

APRIL 11-12, 1985 (Minnesota): *Third Annual OB/GYN Update,* Radisson Plaza Hotel, St Paul. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3-85

MAY 16-17, 1985 (Minnesota): *Primary Care for CNS Trauma and Disease,* Radisson Plaza Hotel, St Paul. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3-85

JUNE 5-8, 1985 (Alaska): Alaska State Medical Association Annual Convention in Haines. Info: Alaska State Medical Association, 4107 Laurel St, Ste #1, Anchorage, Alaska 99508; ph 907/562-2662. g2-5/85

JUNE 22-23, 1985 (Minnesota): *Management of Common Psychiatric Problems in Primary Care,* Breezy Point Resort, Brainerd. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3-85

AUGUST 1-4, 1985: *Second Annual St Paul-Ramsey Trauma Conference* (Fishing & Family Recreation), Fox Hills Resort, Mishicot. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3/85

SEPTEMBER 5-7, 1985 (Texas): American Cancer Society, *Second National Conference on Diet, Nutrition and Cancer,* Shamrock Hilton, Houston. Info: American Cancer Society, Second National Conference on Diet, Nutrition and Cancer, 90 Park Ave, New York, NY 10016. g3-8/85

1985 CME Cruise/Conferences on Selected Medical Topics—Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20-24 CME Category I credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. ***Fly roundtrip free on Caribbean, Mexican, & Alaskan Cruises.*** Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Info: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 516/549-0869. p9-11/84;1,3,4/85

International Childbirth Education Association

to host 1985 Conference

in cooperation with Methodist Hospital who will coordinate the local planning committee.

in Madison, June 20-23

at the Sheraton Inn and Conference Center

The four-day conference is expected to draw 400 to 500 persons from across the nation, including childbirth educators, nurses, physicians, parent advocates, and others interested in the current changes in pregnancy, birthing, and early parenting.

Persons interested in assisting with the conference or learning more details can call Methodist Hospital, Madison, at 608/258-3290.

AMA

JUNE 16-20, 1985: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 8-11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15-19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7-10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21-25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6-9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26-30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1988: Interim House of Delegates, Dallas, TX. ■

RECENT CHANGES IN MEDICARE REGARDING DURABLE MEDICAL EQUIPMENT. Effective February 1, 1985 the Health Care Financing Administration revised payment guidelines for all durable medical equipment (DME) payable under the Medicare program. The changes will cause physicians to alter the way they write prescriptions in order to allow their Medicare eligible patients to be reimbursed for their DME expenses.

Transmittal #1067 to the Medicare carriers Manual changes the method of decision-making as it relates to whether the item is rented or purchased. After February 1, the decision to rent or purchase is still the beneficiary's. However, it is not binding on Medicare as far as payment is concerned. Payment will be made based on the Medicare carriers determination regarding the least costly method of payment (except for items costing less than $120 which will always be purchased). Prior to February 1, 1985, the Medicare beneficiary made the decision to rent or purchase the item and Medicare paid accordingly.

If it is known at the time the prescription is written that the patient will need the equipment for at least nine months, Medicare Part B would pay $720 (80% of $100 Medicare allowable) on a billed charge of $1,000. The patient would have an immediate $180 co-insurance payment to make. If the patient still wants to rent the equipment regardless of Medicare's determination, Medicare would pay seven months rent (applied toward the purchase price), and the patient would owe the final three months rent.

In order that timely payments continue from Medicare on behalf of Medicare beneficiaries, this change will require physicians to furnish more information than in the past. As in the past, a prescription is required for each item.

Most suppliers will work with the prescribing physicians to make sure that the information will be present on the initial and subsequent claims which show a continuing medical need. However, if medical necessity is not shown to the satisfaction of the carrier, (i.e. diagnosis, prognosis, physician estimate in months of need duration), a follow up letter will be sent to the physician indicating that payment will cease if sufficient documentation of Medicare need is not received in 30 days.

Maintenance of purchased durable medical equipment is *not* covered and is an obligation of the patient. If a patient cannot perform routine equipment maintenance required to keep the unit properly functioning, it must be so stated with the reasons explained. It is believed that Medicare will continue to allow rental which includes repair and maintenance. If a certain type of product is medically required, it must also be stated in such instances in the prescription the reasons, i.e., liquid oxygen as opposed to high pressure tanks to support therapeutic ambulation or special add-on equipment for a wheelchair. Supply companies can help determine when this may be required.

In order for this new program to work to benefit the patients, a close cooperation between discharge planners, therapists, physicians, and suppliers is imperative. Suppliers realize the increased burden on physicians and will develop methods to assist you to facilitate payment on behalf of the Medicare beneficiary.

If physicians have specific questions, they are urged to contact the WPS-Medicare Inquiry Services Dept in Madison: (608) 221-4711. ■

PRACTICE MANAGEMENT STUDY COURSES OFFERED. The American Medical Association's Dept of Practice Management has prepared a special series of videocassette and audiocassette courses to help physicians develop their management and marketing skills. Programs are available on "Developing a Marketing Plan for Your Medical Practice;" "Borrowing Money: What A Doctor Needs to Know;" "Medical Collection Study Course," and "Handling Patient Telephone Calls Effectively." For more information on any of these courses call the AMA toll-free at 1-800-621-8335. ■

PHYSICIAN FEE INCREASES SLOW. An economist from the Bureau of Labor Statistics was recently quoted as stating that there has been a substantial drop in the rate of increase of doctors' fees. Daniel H Ginsburg of the Bureau attributes this, in part, to the fact that many doctors froze their fees last March at the suggestion of the American Medical Association. ■

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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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WISCONSIN MEDICAL JOURNAL

vol 84, #4

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APR 26 1985

"Cost-effective care of the geriatric population"

Theme of the 1985 Annual Meeting of the State Medical Society of Wisconsin, April 25-26-27, in La Crosse (see page 23)

APRIL 1985

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CONTENTS

April 1985

SPECIAL FEATURES

President's Page

5 What are you going to do for me in the future?
Timothy T Flaherty, MD
Neenah

Editorials

6 Save a child—save the world

6 MRI
Victor S Falk, MD
Edgerton

7 The computer says
Victor S Falk, MD
Edgerton

Letters

9 Nicaragua—diversified views
Gonzalo Madiedo, MD, PhD
Milwaukee
Sean Keane, MD
Gonzalo Madiedo, MD
Pablo Pedraza, MD
Thomas Schlenker, MD
Lucille Glicklich, MD
Milwaukee
David G Dibbell, MD, FACS
Madison
Henry A Peters, MD
Madison

11 Is your hospital in compliance?
Larry A Lindesmith, MD
La Crosse

29 AMA Physician's Recognition Award recipients

33 AMA Physician's Recognition Award recipients

Public Health

46 Wisconsin and Soviet physicians meet in Chicago

Socioeconomics

48 SMS speaks out on mandated benefits, involuntary commitment laws

SMS testifies on peer review legislation

49 Malpractice premiums to rise 106%

SMS asks business leaders' help on malpractice problem

Joint Finance Committee considers healthcare regs

Malpractice seminar scheduled for May 11

50 WISPAC: A brief profile of the 1985 Wisconsin State Legislature

News you can use

79 Doctor union executive speaks to Dane County Medical Society

AMA Guide for hospital medical staff bylaws available

Have you been receiving complaints from patients about DRGs?

All physicians! Plan to participate in the 1985 PPA census

80 Governor's budget bill

Also in the Legislature

AMA helping states track physician licensing actions

Child abuse conference May 18 in Madison

Biomedical ethics conference coming up June 6 and 7

Malpractice conference May 10-11—Milwaukee

SCIENTIFIC MEDICINE

13 Pneumatic injury from a nailgun
Mark J Mirick, MD
Jeff Kurtz, MD
George Tanner, MD
Wausau

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84, No. 4

CONTENTS

STATE MEDICAL SOCIETY OF WISCONSIN

15 ABSTRACT: Patient selection and results of simultaneous coronary and carotid artery procedures, by *Herbert A Berkhoff, MD* and *William D Turnipseed, MD,* Madison

ABSTRACT: Perihepatitis (Fitz-Hugh—Curtis syndrome), by *Hania W Ris, MD,* Madison

16 *Clonorchis sinensis* infection associated with adenocarcinoma of the gallbladder and cystic duct
Paul Drinka, MD
Greg Sheehy, MD
Madison

19 Clinical and laboratory findings in ten Milwaukee patients with the acquired immunode-ficiency syndrome or prodromal syndromes
Paul A Turner, MD
Kari S Larratt, MS
Timothy R Franson, MD
Michael W Rytel, MD
Milwaukee

ORGANIZATIONAL

23 SMS Annual Meeting focuses on critical medical issues

Dr Pomainville resigns CESF treasurer post

Biomedical ethics conference coming up June 6 and 7

24 ANNUAL MEETING: Professional liability, emergency medical services, and government regulations are key issues for '85 House of Delegates (resolution summaries)

30 SMS launches campaign to improve communications

31 Court halts attempt to get SMS records

Child abuse conference May 18 in Madison

32 Membership Directory—Update

34 Membership facts

42 CES FOUNDATION: Contributions during months of January and February 1985

DEPARTMENTS

51 PHYSICIAN BRIEFS

54 NEWS HIGHLIGHTS

56 PUBLICATION INFORMATION

66 OBITUARIES
William N Young, MD
Milwaukee
Richard E Jensen, MD
Green Bay
Albert P Hable, MD
Marshfield
Donald F Jarvis, MD
Tomahawk
Nicholas D Demeter, MD
Wauwatosa
Russell C Darby, MD
Oshkosh (Wautoma)
William H Studley, MD
Shorewood
Paul B Mason, MD
Sheboygan
Philip W Limberg, MD
Glenwood City
Harry Gonlag, MD
Eau Claire
Walter E Clasen, MD
Wauwatosa
Jerry W McRoberts, MD
Sheboygan

74 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Miscellaneous . . . Advertisers . . . Medical meetings —continuing medical education ■

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5600 member physicians in Wisconsin, comprising 55 county medical societies and 25 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Timothy T Flaherty, MD

What are you going to do for me in the future?

THE ACHIEVEMENTS of our State Medical Society, both in the past and present, are well-documented. The current paramount issues of medical liability legislative reform and more acutely of obtaining relief from the proposed exorbitant increases in malpractice insurance premiums are consuming a major portion of SMS staff time and resources to educate the public and our legislators to preserve the integrity of healthcare in Wisconsin.

Historically, from the time of the "Flexner Report" in 1910 until the passage of Medicare and Medicaid in 1965, physicians and the organization of physicians controlled and were responsible for the healthcare system. We controlled the medical educational requirements, the medical curricula, the licensing of physicians, and also the disciplining of physicians. The revolutionary advances in medical technology and treatments have produced progressive improvements in the quality and length of life, but due to the proliferation of government programs, it is at an annual cost of 400 billion ***inflated*** dollars. Now, all physicians are aware that almost everyone—federal-state-local government, insurance companies, for-profit chains, nonprofit hospitals, large employers, healthcare coalitions, etc—are all trying to control, to limit, or to at least get a piece of that $400 billion.

This almost singular focus on healthcare cost by government, health insurance companies, and payors —while simultaneously tightening the noose of regulation around healthcare institutions and physician-providers—threatens the traditional access and quality of care. The organization of physicians, SMS and AMA, has been the major voice for patient advocacy in this environment of intensified regulation and competition. Our State Medical Society has been active representing and communicating the concerns and opinions of Wisconsin's physicians to the media, to the public, and to the legislators.

I sincerely believe that the State Medical Society represents ***all*** of the physicians of Wisconsin and assuredly ***all*** physicians benefit from the accomplishments of SMS! Disappointingly, there is a small but significant segment of Wisconsin physicians who for a variety of stated reasons have decided not to financially support organized medicine. Examples are: "I couldn't afford it this year." "I don't like the stand they took on this or that issue." "They don't represent me." By far the most frequently stated reason is one of economics; *ie,* they don't believe that membership benefits are worth the "deductible dues" expense.

After reminding those nonmember colleagues about SMS activities in the education of the public on the critical issues (*ie,* malpractice) and the pursuit of legislative reform (*ie,* medical liability), ***ask those nonmember colleagues if they want organized medicine to discontinue these activities?*** We, involuntarily, are assuming the responsibility for these nonpaying passengers and their free ride on the vehicle of organized medicine.

Forecasting future events is at best an imperfect science. I am encouraged by the proactive stand and the relevancy of the State Medical Society to present issues and future strategies.

My immediate request (not for the future) is the delivery by SMS members of sufficient peer pressure, therapeutically applied, to our nonmember colleagues. It will ensure that all Wisconsin physicians will share membership pride in the representation and accomplishments of ***our*** State Medical Society.■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

Save a child—save the world

IN SEVERAL special reports on child abuse and neglect in this Journal, the magnitude of the problem and the various aspects relating to the law were elucidated, and actions to be taken immediately following a report of abuse and neglect were defined. Great strides, not only in a heightened awareness of the problem but also in the enactment of legislation for the protection of the child, have taken place since C Henry Kempe, MD, wrote about the "Battered-Child Syndrome" in 1962.

With the focus centered on legal actions, the physician often feels "left out" or "isolated." Is his role only that of whistleblower? Is the physician hesitant to become involved because of a fear that the "case" may take too much of his time, or worse, that he will lose the family as patients? Some physicians fear that their legal involvement may result in the loss of the family as patients, and thus remove their ability to help the child and family. But '[h]e who helps to save a child is as if he saved the whole world, and he who neglects a child destroys the world.' (Talmud)

The physician's role in the big picture of abuse and neglect has in the past been extremely narrow. That narrow "role" is not obsolete. All physicians must begin to work with other legitimate healthcare providers to allow for better treatment and followup. The current system is not adequate for dealing with the ever-increasing numbers of reports. The facilities currently available for treatment are too few and too complex.

But there are concrete things physicians can do:

1) Develop an understanding that takes into consideration the need for legal as well as medical intervention in some cases—not only to protect the individual child from possible re-assault but also to protect other children in the community.

2) Develop a working relationship not only with law enforcement officials but also with the division of community services in their area. Learn how these particular groups handle suspected or blatant cases of child abuse and neglect and ask about becoming involved in the treatment aspects after the report is made.

Health, legal, and social professionals working together can do much to alleviate the potential problems of children involved in legal proceedings. Anticipatory guidance and emotional support to child victims and families can go a long way in this extremely stressful situation.

3) Develop an understanding that child abuse and neglect is not a single entity. Understand the dynamics of abuse and neglect. More and better treatment programs or program components must be established.

4) Work for the development of prevention programs relating to child abuse and neglect. This cannot be the burden of one profession alone; it needs the expertise of a multidisciplinary team. No single prevention strategy can deal with the complexity of the problem. Primary prevention requires active outreach and education.

The task is formidable and not readily conducive to immediate change. The wheels must be put in motion, not only for the welfare of the child but also for the good of the family and entire community. A well-executed child abuse program will inevitably reveal the physician in his or her strongest role—healer and advocate.

MRI

AN ARTICLE in the *Wisconsin State Journal* of Madison March 17 reported that in addition to the MRI machine at University Hospital that three Madison hospitals had requested state authorization to build a joint MRI facility. The consortium of Madison hospitals had sued Secretary of Health and Social Services Linda Reivitz because she had refused to even send the hospitals an application form. Secretary Reivitz was ordered to send them the application, although she is not required to approve it.

The article pointed out that MRI (Magnetic Resonance Imaging) machines cost about $2 million and cost another $900,000 or so to operate. Also the machine requires special housing because it uses a magnet and can't be around a great deal of other metal. It is estimated that the cost to a patient for an MRI scan would be approximately $600.

The Madison hospital radiologists (and undoubtedly those in Milwaukee and other medical centers) want their own MRI because they feel that the unit will be essential to quality medical care in the future. They also fear that if only the University has an MRI machine, the other hospitals and radiologists would be limited in their ability to compete for patients and would be in a second-rate status.

The state's attitude is that the MRI diagnostic device is still ex-

perimental and there are two already operating in Wisconsin. Also since the state would be billed for diagnostic tests performed on Medicaid patients at $600 each, the MRI scan would be expensive.

But is the state going to play God, "knowing best" what is good for the people's health and what isn't? A few years ago the state was openly advocating that institutions share costly equipment and facilities. Madison's private hospitals and physicians are making sense with their idea for sharing an MRI. They should be encouraged, not stonewalled by the state.

—*Victor S Falk, MD,* Edgerton

The computer says

A 73-YEAR-OLD patient was admitted to the hospital with a badly comminuted fracture of her wrist. This was promptly reduced and a cast applied. Because of her age and the fact that she lived alone in another town, it was deemed prudent to observe her overnight for frequent checks of the circulation to her hand.

She was discharged 19½ hours after admission. This resulted in a denial from WiPRO. The WiPRO computer says that the patient was in the hospital two days and kept a hospital bed "tied up for two days." The hospital's business office billed the patient only for the day of admission and not for the day of discharge, which is the customary procedure.

How in the name of Hippocrates can a computer spit out a figure of two days after a 19½ hour hospital stay? The frustrating aspect of the situation is that arguing with a computer is like tilting with a windmill.

—*Victor S Falk, MD,* Edgerton

Editorial Board comment: *The WiPRO computer . . . another monster born of "cost control" feeding on the mother's milk of those it is supposed to serve. However, we do have to keep in mind that the computer only reflects the confusion of the people who tell it what to do—if these individuals don't realize that 19 hours is less than, not more than 24 hours, should we blame the computer?* ■

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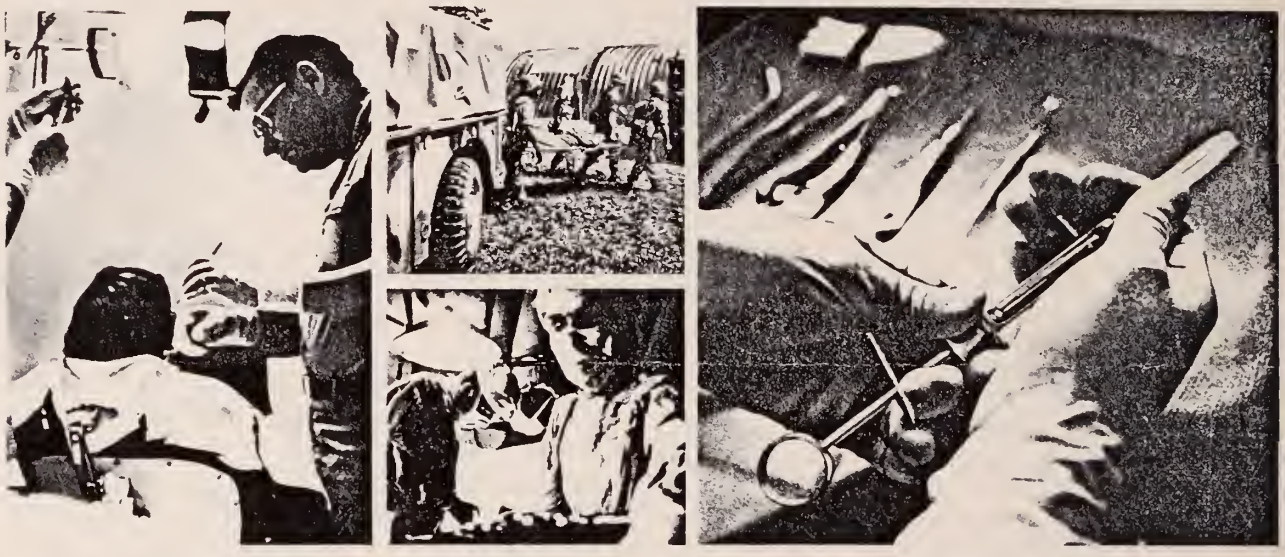

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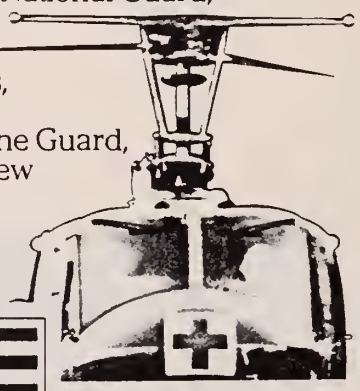

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The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Nicaragua—diversified views

TO THE EDITOR: I have read with interest Doctor Falk's letter about Nicaragua.[1] He believes that the cooperation between Wisconsin and Nicaragua was easier before the revolution. He gives the reader a totally negative picture of today's situation in the country and expresses how comfortable he felt working there at the time when the dictator Somoza was in power. His views are certainly in sharp contrast with those of Doctor Schlenker.[2] I have been at several presentations given by Doctor Schlenker after his extensive trips to Nicaragua. He, as many others,[3] shows evidence that the health conditions for the entire population have improved dramatically after the revolution in spite of the kidnappings and assassinations of health personnel and destruction of health facilities perpetrated by the United States' trained and financed "contras." Doctor Falk gives some facts like the burning of Moskito villages in the eastern part of Nicaragua and the lack of medical supplies suffered by the local physicians. Regretfully he fails to explain that these and many other calamities (like the mining of the ports) are the consequences of the campaign of the "contras" against the Sandinistas. Recently, for example, a vaccination team directed by Dr Gustavo Siquiera, vice dean of the Managua campus of the School of Medicine in Nicaragua, was attacked by Mr Reagan's "freedom fighters." After killing three of the health workers and destroying the vaccine, Doctor Siquiera and three other persons were kidnapped. Their fate is still unknown.[4]

Doctor Falk's apprehension about the presence of foreigners in Nicaragua is also interesting. I hope that Doctor Falk agrees that these foreign doctors, nurses, and other individuals who try to serve the people will have a greater ideological impact upon the Nicaraguans than the guerrillas who assassinate women and children.

Our concern as physicians should be the well-being of the people above politics and nationalities. We should realize that the United States is not improving the health of the people in Central America by financing guerrillas, *ie* "freedom fighters" to overthrow the government of Nicaragua which continues to make progress in improving the health of the people.

We should be encouraged, however, that Wisconsin has been so helpful to Nicaragua in this critical time. Large shipments of medical supplies have been sent.[5] Five physicians from Wisconsin, together with 196 from other states, have generously donated their time and effort travelling to Nicaragua in September 1984 to participate in the second annual Nicaragua-United States Colloquium on health. In this way the United States will be able to exercise influence upon other nations by means other than brutal force.

[1]Falk VS: *Wisconsin Med J* 1984;83:12.
[2]Schlenker T: *Wisconsin Med J* 1984:83:9.
[3]Halperin DC, Garfield R: *N Engl J Med* 1982; 307:308.
[4]*New York Times*, Feb 10, 1985.
[5]*Milwaukee Journal*, Nov 28, 1984.

—*Gonzalo Madiedo, MD, PhD*
8700 Wisconsin Ave
Milwaukee, Wisconsin 53226

Editorial Board comment: American Medical News, *March 1, 1985, states: "The medical people may have been in uniform and carrying weapons, which might have confused the contras, said Armstrong Wiggins, the Indian leader in Washington. Now that it is clear that they are medical people, they should be released, Wiggins said."*

TO THE EDITOR
(Press release dated
February 6, 1985, Milwaukee):

Dr Gustavo Siquiera, vice-dean for medical sciences at the UNAN medical school in Managua, Nicaragua, along with three other healthcare workers were kidnapped on the morning of January 26 by as yet unidentified "contra" forces from the island of Rama Quay situated about 10 kilometers from Bluefields on Nicaragua's East Coast. Doctor Siquiera and the others were there at that time as volunteers participating in a campaign to vaccinate the island's children. During the attack, three people were killed by the "contras" and all of the vaccination supplies were stolen.

We, as physicians practicing in Milwaukee and as faculty members of the Medical College of Wisconsin, appeal to the governments of Costa Rica and Honduras and to the government of the United States to apply pressure on the contras to save the lives of these four Nicaraguans and to facilitate their release.

We also ask every doctor and every nurse and all other healthcare workers in this community to speak out loudly now in protest over this cruel attack on our colleagues in Central America. And we petition the US government to reject both publicly and

privately all activities that serve to promote this kind of vicious and immoral act.

—*Sean Keane, MD*
Orthopedic Surgery
St Francis Hospital

—*Gonzalo Madiedo, MD*
Assistant Professor of Pathology
Medical College of Wisconsin

—*Pablo Pedraza, MD*
Cardiovascular Surgery
St Mary's Hospital

—*Thomas Schlenker, MD*
Clinical Instructor of Pediatrics
Medical College of Wisconsin

—*Lucille Glicklich, MD*
Associate Professor of Psychiatry
Medical College of Wisconsin

Milwaukee, Wisconsin

TO THE EDITOR: It is my understanding that there have been two letters to the Journal asking Wisconsin physicians to decry the activities of the Contra guerrillas in Nicaragua against the Sandinista government. These complaints specifically involve the kidnapping of a military health team which reportedly was involved in vaccination of indigents on the East coast of Nicaragua. I would like to make a couple of points about such letters supporting a particular political point of view:

1. Anytime difficulties accrue in an area such as Central America there is usually polarization of the political and moral viewpoints of sympathetic observers. The above mentioned letters reflect such polarization. For example, the kidnapped health team was actually in military garb and carrying weapons at the time, (this is against the rules of the Geneva Convention). This certainly would create problems in identifying these military persons as noncombatants. Such details were not mentioned in the letters though they are extremely important in the interpretation of the incident.

2. These same letters should have raised equal outcries against the Sandinistas who with their new, absolutely state-of-the-art M-1 Russian-supplied attack helicopters created havoc on the East coast. These helicopters are more than a match for the best attack helicopters owned by the United States military and are vastly superior to any aircraft owned by other countries in Central America.

As a demonstration of the power of the new Russian choppers, the Sandinistas essentially eliminated Greytown from the face of the earth. Greytown was one of the oldest towns on the East coast of Central America. The Sandinistas felt that it was sympathetic to the rebel cause and two of these attack helicopters, each carrying the destructive capability close to a squadron of B-17s, erased Greytown from its geographic location. I had the opportunity to talk to some of the refugees from the area as little as three weeks ago and their description of the holocaust made the Mai Lai incident look like a simple parlor monopoly game.

It has also been recently brought to our attention that the island of Rama Cay was also leveled by the Sandinistas, probably by the same mechanism. Rama Cay was the home of the Rama Indians, a very small and ethnically discrete group on the Nicaraguan coast. At one time they were politically nonaligned and preferred to be left alone. The previous regime actually did this. Evidently, the Sandinistas have elected not to.

3. Let us also be very careful how we describe the Contras as rapists, murderers, and militarists. Some of them indeed are old guard Somosistas. This does not immediately label them as rapists and murderers. Most, in fact, are disenfranchised Mosquito Indians who had supported the Sandinista revolution before it turned upon them. Another large group is old disaffected revolutionaries headed by one of the top generals in the Sandinista revolution army. This general became totally disenchanted with the Communist/Russian/Cuban backed takeover of the revolutionary government. Many more are current defectors from the Sandinista army who do not approve of the militaristic changes in their country.

4. Extreme and naive stands taken on both sides only serve to muddy the waters. The State of Wisconsin has always had a strong and sympathetic relationship with Nicaragua and the Nicaraguan people. We should be sympathetic to their political as well as ethnic diversity. It is not helpful to us in understanding their problems and the problems with Central America to read strident letters from ostensibly well-meaning physicians who in fact are probably only quoting the partyline which has been fed them by an admittedly shakey Managuan government.

—*David G. Dibbell, MD, FACS*
Professor and Chairman
Division of Plastic and Reconstructive Surgery
University of Wisconsin School of Medicine
600 Highland Avenue
Madison, Wisconsin 53792

TO THE EDITOR: I read with interest the letters describing both the political situation and the state of health in Nicaragua now as opposed to prerevolutionary days. Based upon my experience in that country on eight or more occasions before the revolution and more recently last June, I would have to state that indeed there are massive changes that have taken place. Prior to the revolution, between 1968 and 1978, an average of 10

medical students yearly from the University of Wisconsin Medical School spent three months in projects relative to health in various Mosquito Indian villages on the east coast of Nicaragua. An additional 10 students from three other universities likewise participated yearly, and this resulted in considerable improvement in the health of these Indian communities. In addition to this, more than a dozen physicians from Wisconsin donated their time serving in various capacities largely on the east coast of Nicaragua. Health care facilities were built by Wisconsin at several sites on the Rio San Juan River and there was a large influence on the Rio Coco River at Waspam and at Bilwaskarma where paramedical and medical personnel participated. Before the earthquake, and especially after the earthquake, the Wisconsin Hospital Association and other people working with the Wisconsin/Nicaragua Partners sent trainloads of hospital equipment to Nicaraguan hospitals throughout the country, in addition to which a 1,000 student school was built in Managua which is still in operation. Thirteen Wisconsin communities were linked with counterpart cities in Nicaragua with interchange of people, projects that linked churches, schools and service clubs in the two countries; the Wisconsin Medical Society worked with their counterpart in Nicaragua. Vaccination campaigns were conducted throughout Central America including Nicaragua on at least two occasions that included Wisconsin physicians and personnel. Shortly after the revolution, the new government destroyed over 61 Indian villages, including the large city of Waspam and this included resettlement in camps for these Indian families far from their ancestral homes. This made continuance of medical activities in eastern Nicaragua impossible. Doctor Madiedo mentions the recent kidnapping of a vaccination team that was working on Rama Key off the coast of Bluefields. He does not add that these personnel were subsequently released by the contras. Although the general health of the Nicaraguan Indians may be improving in recent years, this cannot have included their peace of mind; and it is this mistreatment of east coast Indians that we should all protest.

—*Henry A Peters, MD*
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University Hospital and Clinics
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Madison, Wisconsin 53792

Is your hospital in compliance?

TO MY COLLEAGUES: Are your asthmatic patients worsening after admission to the hospital because someone in the next bed is smoking? Do you have to brown bag your lunch in your office rather than go to the hospital cafeteria because of the dense cigarette smoke? Are your ward secretaries at risk from the ill health effects of secondhand smoke because visitors smoke in front of the desk?

The State Medical Society urges physicians to take an active role in effecting the compliance of hospitals with Wisconsin's new Clean Indoor Air Act, which states that smoking is not permitted in hospitals and other public buildings except where smoking areas are specifically designated by posted signs.

In a brief meeting a subcommittee of the hospital medical staff along with an administrative designee can rapidly devise an appropriate plan and arrange for the placement of signs. In accordance with the law, signs designating smoking areas need not be costly, but should have letters at least 3/4″ in size and include the international smoking-allowed sign. (Posting no-smoking signs in nonsmoking areas is optional, but probably a good idea since the general public does not yet realize that hospital areas which are not posted as smoking areas are automatically nonsmoking areas.)

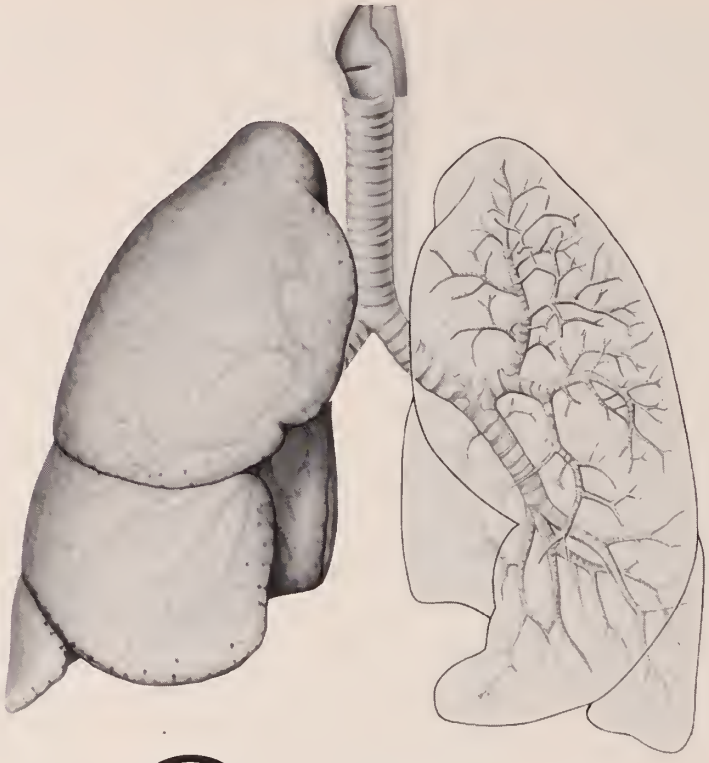
While some hospitals have designated the entire hospital as a no-smoking area, others have provided smoking areas within lounges or have provided separate lounges for smokers. They have also set up no-smoking policies for patient rooms with exceptions for certain private rooms or semi-private rooms in which both patients wish to smoke.

The hospital cafeterias can generally be divided into separate smoking and nonsmoking areas, and a few waiting rooms can be designated as smoking areas.

The doctors of the state of Wisconsin were steadfast in the campaign to obtain this Clean Indoor Air Law. Now we need to act to be sure that the law is enforced in hospitals to protect our patients, our employees, and ourselves from the effects of secondhand smoke and to discourage smoking —the number one preventable cause of emphysema, lung cancer, and arteriosclerotic heart disease.

—*Larry A Lindesmith, MD,* La Crosse
Vice Chairman
Committee on Environmental
and Occupational Health
State Medical Society of Wisconsin ■

Consider the causative organisms...



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Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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Pneumatic injury from a nailgun

Mark J Mirick, MD; Jeff Kurtz, MD; and *George Tanner, MD*
Wausau, Wisconsin

ABSTRACT. *The authors present a case history involving a high-pressure air injection injury. The evaluation of the prognostic indicators: substance, location, amount, neurologic vascular damage, led to conservative therapy with close supervision and a favorable outcome with no functional impairment.*

Key words: Pneumatic injury, High-pressure injection

HIGH-PRESSURE injection injuries are primarily occupational accidents of certain industries. Previous reports have demonstrated that the severity of the injury was related to the composition of the substance injected. Devastating injuries have been described for paint and grease gun injuries, and the reported substances injected include paint, grease, diesel oil, hydraulic fluid, plastics, wax solvents, cement, river water, and nitrogen gas.[1-19] The following case describes a nailgun injury that caused a massive injection of air without other agents.

CASE REPORT

Prehospital events: A 21-year-old construction worker was using a nailgun when he accidentally shot a nail into the back of his left wrist. Unfortunately, the high-pressure air hose that runs the gun was also nailed to the man's wrist. This caused air at approximately 200 lb per square inch to be injected along the entry wound path of the nail. A companion immediately pulled the air hose and nail from the man's wrist, and he subsequently was brought to the Emergency Department.

Condition upon arrival: The initial findings consisted of a puncture wound/entry wound at the dorsal area of the left wrist approximately over the capitate. There was no exit wound or obvious foreign body remaining. There was minimal tenderness at the site. Circulation, motor, and sensory exam was intact and the patient had full range of motion at the wrist. The dorsum of the hand was markedly swollen and there was a slight increase in the circumference of the forearm. No signs of compartment syndrome existed. There was palpable subcutaneous emphysema of the hand (excluding the palm), fore-

Figure 1 (A&B)—*Shows subcutaneous air from injection injury.*

From the Department of Emergency Medicine (MJM) and the Department of Surgery (JK,GT), Wausau Hospital Center, Wausau. Reprint requests to: Mark J Mirick, MD, Dept of Emergency Medicine, Wausau Hospital Center, Wausau, Wis 54401 (phone 715/847-2160). Copyright 1985 by the State Medical Society of Wisconsin.

arm, and arm. Air could be seen bubbling from the entrance wound. X-ray films revealed massive subcutaneous air of the left upper extremity as well as air up into the neck on chest x-ray study (Fig 1 & 2). There was no bony injury. The patient's immunization status was checked.

Subsequent events and treatment: The wound edges were sharply excised and thorough irrigation and debridement were performed. The wound was left open and the patient started on parenteral penicillin and cefazolin. Steroids were not administered.

The patient was admitted to the hospital for close observation. This decision of conservative management was based on two favorable prognostic factors: the substance injected was air and the location was not into a small confined space.

The patient's hospital course was unremarkable. No neurovascular or infectious problems developed. After five days of elevation, the subcutaneous air had been absorbed and was virtually gone.

He was discharged with normal function of the left upper extremity and was able to resume work ten days after the injury. A followup examination at two weeks was normal.

DISCUSSION

Numerous articles concerning high-pressure injection injuries have appeared since the original report by Rees.[20] The pathophysiology involves chemical irritation, inflammation, circulatory embarrassment, and vessel thrombosis with resulting gangrene, slow healing, or fibrosis and sinus formation.

The mechanism of obliterative thrombosis and necrosis has been postulated to involve sudden massive thrombosis caused by the injected substance volatilizing, acute temporary arterial spasm, venous obstruction, and arterial obstruction secondary to increased pressure (compartment syndrome). Whether all these factors are operational has been the subject of previous reports.[2,3,16]

Well documented, however, is the ability to predict prognosis based on certain factors surrounding the accident.

A. Substance injected—the toxicity relates to the volatility of the agent; *ie,* solvents > paints > oil > grease.

B. Location injected—the smaller the potential space, the worse the prognosis; *ie,* fingers > palm > arm.

C. Time to intervention—in general the longer the delay in definitive therapy, the worse the prognosis. Unfortunately, in some cases despite early intervention, the functional outcome has been poor.

D. Amount injected—the more material into a confined space, the worse the outcome.

The emergency medicine physician is likely to see the injury first, and it is his or her responsibility to recognize that the seemingly trivial appearing lesions are truly surgical emergencies. Radiographic evaluation is essential.[14] The subsequent treatment is usually surgical although there are published reports advocating conservative therapy for a very select subgroup based upon evaluation of the prognostic indicators. The basic principles of immediate debridement, decompression (including neurolysis, arteriolysis, tenolysis, and fasciotomy), and evacuation should strictly be adhered to when dealing with the more devastating injuries. Amputation becomes likely for a paint injury into a finger, otherwise amputation as a primary procedure is contraindicated.[4,10]

Figure 2—*Shows subcutaneous air from injection injury.*

Kendrick described the first case of a conservatively managed high-pressure injection injury based upon sound evaluation of the prognostic indicators.[12] His criteria for conservative therapy included:

1. Injected agent is less damaging.
2. Favorable anatomical site.
3. No signs of central nervous system damage.
4. Adequate close supervision with the expertise to apply surgical therapy if needed.

Other reported cases where the conservative approach was used include air injected into the left thenar eminence,[7] and nitrogen gas injected into the femur and thigh during a closed intramedullary nailing with a power reamer.[18] In these cases decompression, or amputation, was not needed and the patients recovered without functional impairment.

ACKNOWLEDGMENT: The authors wish to thank the Wisconsin Chapter, American College of Emergency Physicians, for its support in preparation of this manuscript.

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ABSTRACTS

Patient selection and results of simultaneous coronary and carotid artery procedures

HERBERT A BERKOFF, MD; WILLIAM D TURNIPSEED, MD, Department of Surgery, University of Wisconsin Clinical Science Center, Madison, Wis: *Ann Thorac Surg* 1984 (Aug);38:172-175.

The high incidence of severe coronary artery disease in patients with symptomatic carotid artery disease makes careful evaluation of both carotid and coronary systems important to the successful short-term and long-term management of these patients.

They have established guidelines for patient evaluation and procedure selection based on symptomatic assessment of each system, supplemented by angiographic and hemodynamic data. With this information, three operative groups are established: (1) carotid artery operation first or alone, (2) coronary artery bypass grafting first followed by carotid artery operation, and (3) simultaneous carotid artery and coronary artery bypass procedures. The benefit of this selection process has been shown by the low operative mortality in each group. This report presents their selection process and evaluates the results for 21 patients in the group having simultaneous carotid and coronary artery procedures. ■

Perihepatitis (Fitz-Hugh—Curtis syndrome)

HANIA W RIS, MD, Dept of Pediatrics, University of Wisconsin Medical School, Madison, Wis: *J Adolescent Health Care* 1984;5:272-276

Perihepatitis, or Fitz-Hugh—Curtis syndrome (FHC), is a complication of pelvic inflammatory disease (PID). Although in the past *Neisseria gonorrhoeae* was thought to be the only etiological agent, recent data indicate that *chlamydia trachomatis* can produce the syndrome. Because cervical cultures frequently fail to demonstrate the presence of C. *trachomatis,* the serologic microimmunofluorescence antibody test is essential to diagnosis; the antibody titer in FHC syndrome is markedly higher than in PID without FHC syndrome. The classic presenting symptom of perihepatitis is severe right upper quadrant abdominal pain. If unnecessary diagnostic and surgical procedures are to be avoided, the FHC syndrome in the sexually active young woman must be included in the differential diagnosis of abdominal pain irrespective of its location. Tetracycline is recommended for treatment. If tetracycline is contraindicated, erythromycin may be used. ■

Clonorchis sinensis infection associated with adenocarcinoma of the gallbladder and cystic duct

Paul Drinka, MD and *Greg Sheehy, MD*
Madison, Wisconsin

ABSTRACT. *Infection with* Clonorchis sinensis, *the "Chinese liver fluke," is common in residents of Southeast Asia. We present a case of a 33-year-old Laotian who developed acute right upper quadrant pain, low-grade fever, and elevations in bilirubin and transaminase levels. All of these parameters improved spontaneously. This episode may represent low-grade "Oriental cholangitis." Five weeks later the patient presented with painless jaundice and was found to have adenocarcinoma of the gallbladder and cystic duct. Biliary secretions revealed ova of* C. sinensis. Clonorchis *infection has been implicated previously in the pathogenesis of both Oriental cholangitis and adenocarcinoma of the* intrahepatic biliary radicles.

Key words: Liver fluke, *Clonorchis sinensis*, Biliary carcinoma, Oriental cholangitis

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THE AMERICAN physician is increasingly called upon to care for immigrants from Southeast Asia.[1] Optimal care requires familiarity with pathological states endemic in this population. We report a case of infection by *Clonorchis sinensis* (Chinese liver fluke) associated with adenocarcinoma of the gallbladder and possibly low-grade cholangitis.

CASE REPORT. A 33-year-old Laotian male presented to the Madison General Hospital Emergency Room in November 1981 with a four-day history of progressive right upper quadrant and periumbilical pain. He denied constitutional symptoms, change in bowel or bladder habits, or use of alcohol.

On examination he appeared in mild distress. Vital signs showed a blood pressure of 120/70 mmHg, a pulse rate of 72/min, and a temperature of 37C (98.6F) orally. Direct tenderness in the right upper quadrant without rebound was present. The remainder of the examination was unremarkable.

Laboratory data are presented in Table 1. The white blood cell count was 7,800/μl, with 37% polymorphonuclear leukocytes, 8% bands, 2% basophils, 1% eosinophils, 26% lymphocytes, and 26% monocytes. Hemoglobin was 13.4 g/dL. Hepatitis B surface antigen was absent, and two blood cultures were negative. One stool culture revealed normal bowel flora and one stool was negative for ova and parasites. The serum titer of antibody to *Entamoeba histolytica* was less than 1:64 (normal). Other laboratory tests were within normal limits, including cholesterol and erythrocyte sedimentation rate.

Barium contrast x-ray studies of the upper gastrointestinal tract were normal. There was no visualization on oral cholecystogram. Ultrasound revealed a dilated gallbladder and a layering of echogenic material consistent with milk of calcium bile. Some dilatation of the intrahepatic bile ducts was noted. Chest x-ray film and liver scan were normal.

The patient's hospital course was one of prompt resolution of symptoms and signs, with some improvement of laboratory parameters within 48 hours of admission (Table 1). At the time, it was believed that the patient had passed a common duct stone. Since he was asymptomatic and wished to return to work, he was discharged to return in one week.

He was seen again a month later when he presented with painless jaundice. There had been no recurrence of abdominal pain. He was in no distress. Examination was unchanged from the previous month except for icterus and the absence of abdominal tenderness (Table 1). Complete blood count revealed a white blood cell count of 6,900/μl with 35% eosinophils. Prothrombin time and partial thromboplastin time were normal. Multiple stool samples were examined, and some were positive for ova whose similar horizontal

and vertical dimensions were more consistent with *C. sinensis* than with *Opisthorchis felineus* or *O. viverrini.*

Ultrasound again showed generalized dilatation of the intrahepatic ductal system. Transhepatic cholangiogram confirmed massive dilatation of these ducts, and contrast material did not pass into the common bile duct on immediate or delayed films.

Surgical exploration revealed a 2-cm mass in the gallbladder just distal to the cystic duct. The apex of the gallbladder was flaccid. The distal common bile duct was small, rigid, and fibrotic. Bead-like dilatation of the proximal common duct was noted. Biliary dilatation was very prominent at the porta hepatis and proximal to it.

A cholecystectomy was performed. Examination of frozen sections revealed no carcinoma. Because of the proximal biliary dilatation and the appearance of the distal common bile duct, a bypass procedure was performed. The dilated proximal hepatic duct was opened. It was impossible to pass a probe down the distal common bile duct. The jejunum was attached to the common hepatic duct proximal to the mass, and an end-to-side jejunojejunostomy was performed. No large biliary calculi were encountered. Carcinoma was not suspected at the time of surgery.

Pathological examination of biliary fluid revealed ova consistent with *C. sinensis.* Permanent histologic sections demonstrated an adenocarcinoma of the gallbladder neck and cystic duct, infiltrating the entire thickness of the wall. There was no evidence of the adult worm in any of the sections.

Postoperatively, the patient was treated with 4000 rad to the gallbladder bed and completed five of eight cycles of FAM (5-fluorouracil, adriamycin, and mitomycin-C). Fourteen months after diagnosis he was without signs of tumor recurrence and was working full-time. Subsequently, he was lost to followup.

DISCUSSION. Infection with *C. sinensis* is common in Southeast Asia, southern China, and Korea. A large autopsy series from Hong Kong, published in 1964, placed the prevalence of 65% in individuals over one year of age.[2] Many infected individuals are asymptomatic.

The parasite's life cycle cannot be completed in North America because the intermediate host is absent. The adult flatworm inhabits the biliary system. Eggs are passed in human feces and ingested by suitable snails. In the snail the parasite matures to the free-swimming cercaria stage, which penetrates the skin of a suitable fish and encysts in muscle. Uncooked fish, a delicacy in the Orient, is the source of human infection. Encysted parasites are released as metacercaria in the duodenum and migrate up the ampulla of Vater into the small biliary radicles where they mature. Adult flukes measure approximately 15 mm; they may live up to 20 years.[3] They may be carried downward into the common bile duct. Hou[4] reports that:

> At autopsy as well as surgical operations one finds the common duct and hepatic ducts filled with worms. In cases of heavy infestation the number in the common bile ducts may exceed a hundred.

In one postmortem study, 28 out of 300 individuals infected with *Clonorchis* had flukes in the gallbladder.[2] In another study flukes were found in the gallbladder in 11 cases, but in only one were they living.[4]

Flukes anchor themselves to the biliary epithelium and can pull themselves forward.[3] Their presence in the intrahepatic bile ducts results in epithelial desquamation, excess mucus production, and eventual adenomatous hyperplasia and abundant connective tissue formation.[4] Development of biliary obstruction and adenocarcinoma may be related to this process. *Clonorchis* infection has been associated with ductal carcinoma in animals.[5] A human postmortem study of 30 cases of exclusively *intra*hepatic ductal adenocarcinoma without cirrhosis showed multiple independent foci of tumor origin and varying degrees of histological differentiation. This process was superimposed

Table 1: *Serial laboratory data related to hepatobiliary system*

Date	SGOT (0-50) mU/ml	Lactic dehydrogenase (100-225) mU/ml	Gamma glutomyl transferase (0-60) mU/ml	Alkaline phosphatase (15-100) mU/ml	Total bilirubin (0.1-1.1) mg%	Amylase (5-81) Iμ/L
FIRST ADMISSION						
11/19/81	530	431	560	167	1.3	90
11/20/81	231	240	650	227	3.6	—
11/21/81	79	174	578	206	1.9	—
SECOND ADMISSION						
12/22/81	45	206	209	185	7.4	96
12/24/81	38	175	174	192	7.6	—

on the ductal hyperplasia presumably induced by mechanical and chemical irritation from *Clonorchis*. Flukes were identified in 93% of these cases.[6]

Belamaric, in a postmortem pathological study from Hong Kong, demonstrated that 18 of 19 patients with well-differentiated adenocarcinoma of the intrahepatic biliary system, without cirrhosis, had adenomatous hyperplasia and grossly visible fibrosis and dilatation of the bile ducts, as is seen in severe *Clonorchis* infection. Flukes were found in 15 of these cases. Such gross ductal changes were observed in only one-third of control patients without bile duct carcinoma.[7] Gibson reported that in 17 cases of intrahepatic adenocarcinoma from Hong Kong, *Clonorchis* flukes were noted in 65%, as compared to 38% of controls.[8] Thus, individuals infected with *C. sinensis* are apparently at higher risk of *intra*hepatic ductal adenocarcinoma than uninfected individuals.

The parasite has also been associated with a noncarcinomatous entity known as "Oriental cholangitis." Oriental cholangitis has been reported as the third most common cause of acute abdomen in the Hong Kong area, exceeded only by appendicitis and peptic ulcer disease.[9] The characteristic presentation is the acute onset of right upper quadrant pain associated with fever and jaundice. Attacks may be recurrent. In the majority of cases, enteric bacteria can be cultured from the bile.

In the usual case of cholangitis in the western world, the gallbladder is the nidus for obstructive cholesterol stone formation. Oriental cholangitis, in contrast, is a disease of the bile ducts associated primarily with bilirubin stone formation, strictures, and abscesses.[9,12] Obstruction to bile flow in *Clonorchis* infection may be caused by at least four entities: carcinoma, mechanical effects of the flukes themselves,[13,14] adenomatous hyperplasia,[4] or bilirubin stones. Microscopic examination of pigment stones from 42 patients from Hong Kong with Oriental cholangitis revealed morphological elements of *ascaris lumbricoides* from 16 and *Clonorchis* in 8.[15] Parasites that can invade the biliary system (*A. lumbricoides* and *C. sinensis*) were identified in 7 of 14 patients with Oriental cholangitis in a series from Los Angeles.[16] In the case of *Clonorchis* infection, rates of stool isolation may be lowered by the toxic effects of Gram-negative bacterial biliary infection and Hypaque® on the fluke.[10,17]

Our patient's first admission illustrates the association between *Clonorchis* infection and biliary pain, fever, and elevated bilirubin, and may have been an episode of Oriental cholangitis. The transient nature of the pain and initial improvement in chemical parameters suggest transient obstruction precipitated by a stone, worms, or tumor tissue that was subsequently sloughed. The development of painless jaundice five weeks later proved to be secondary to extensive fibrosis and/or obstructing carcinoma. Based on the association of *Clonorchis* and *intra*hepatic biliary carcinoma,[6,7,8] we questioned the role *Clonorchis* may have played in our patient's adenocarcinoma of the gallbladder and cystic duct. The studies of *intra*hepatic adenocarcinoma and *Clonorchis* did comment on *extra*hepatic biliary carcinoma. Hou's study excluded adenocarcinoma originating in the gallbladder and stated that "the gallbladders of this series failed to show either hyperplasia or anaplasia of the epithelial cells" —presumably the premalignant lesion;[6] Belamaric's study found involvement of the extrahepatic bile ducts in 2 of 19 cases;[7] and Gibson stated that "carcinoma of the extrahepatic or major bile ducts, although not uncommon in Hong Kong, is less clearly associated with clonorchiasis than is cholangiocarcinoma arising within the liver itself."[8]

In summary, *Clonorchis* is associated with intrahepatic ductal adenocarcinoma and possibly with extrahepatic ductal adenocarcinoma. *Clonorchis* may be found in the gallbladder, but in one series gallbladder epithelial hyperplasia was not seen. Although the literature does not strongly support an association between adenocarcinoma of the gallbladder and cystic duct with *Clonorchis* infection, our case raises the possibility of such an association. We report this case in the hope of raising physicians' awareness of *Clonorchis*-associated biliary disease.

Any patient with biliary signs and symptoms who gives a history of residence in an endemic area should be evaluated with multiple stool examinations for ova and parasites. Unfortunately, there is no approved medical treatment for *Clonorchis* infection, although praziquantel is promising.[18,19,20] Appropriate antibiotics are indicated for superimposed Oriental cholangitis caused by enteric organisms. A surgical approach is considered necessary to relieve biliary obstruction and should include a drainage procedure.[9,10,11,16] Patients infected with *Clonorchis* should be considered at risk for development of biliary carcinoma.

REFERENCES available upon request to the authors.■

Clinical and laboratory findings in ten Milwaukee patients with the acquired immunodeficiency syndrome or prodromal syndromes

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ABSTRACT. *Three patients meeting the Centers for Disease Control's definitions of acquired immunodeficiency syndrome (AIDS) and seven with findings suggestive of impaired cellular immunity were studied for early laboratory markers of AIDS. The three AIDS patients had* Pneumocystis carinii *pneumonia and other opportunistic infections and had T-lymphocyte subset ratios ≤0.5. Of the seven patients with prodromal syndromes, three had ratios ≤1.0.* In vitro *interferon response to mitogens and antigens was impaired in all AIDS patients, and only this group had an unusual acid-labile interferon alpha detectable in their serum. We conclude that of all parameters studied, only interferon responses may serve as a useful marker of AIDS, and that interferon may play an important role in AIDS pathophysiology.*

Key words: Acquired immunodeficiency syndrome (AIDS); Acid-labile interferon; *Pneumocystis carinii* pneumonia; T-lymphocyte subsets

As of January 1985, the Centers for Disease Control (CDC) in Atlanta have received nearly 7,700 reports of cases of the acquired immunodeficiency syndrome (AIDS) in the United States.[1] First described in mid-1981, the syndrome is characterized by the development of opportunistic infections and/or malignancies in previously healthy patients secondary to a selective depletion of a specific group of T-lymphocytes known as helper or inducer cells. This depletion may occur as a result of infection of these helper cells with a human T-cell lymphotropic virus.[2] The disease has been reported in certain population groups, primarily homosexual males, intravenous drug abusers, and hemophiliacs. Epidemiologic data suggest that transmission of the agent occurs in a similar fashion to transmission of the hepatitis B virus, through contact with blood and blood products and through intimate personal contact. AIDS has also been reported in Haitian immigrants and heterosexual partners of patients with the disease.[3]

Opportunistic organisms commonly found in AIDS patients include but are not limited to *Pneumocystis carinii, Candida albicans,* herpes simplex, *Mycobacterium avium intracellulare,* cryptosporidia, cytomegalovirus, and *Toxoplasma gondii.* Kaposi's sarcoma is the most frequent malignancy found in these patients with or without an opportunistic infection, but malignant lymphomas of several histologic types also have been described.

Several immunologic abnormalities have been reported in AIDS patients including lymphopenia, suppression of cell-mediated immunity, hypergammaglobulinemia, and the presence of circulating immune complexes.[4] Other abnormalities that have recently been described include the detection of an unusual form of leukocyte interferon alpha (IFN-α) in the serum of patients with AIDS and with prodromal AIDS syndromes.[5,6]

In an attempt to identify any early markers of AIDS, we studied the clinical and immunologic abnormalities in ten Milwaukee patients with AIDS or syndromes suggestive of impaired cellular immunity.

METHODS

Patient selection. Between January 1983 and June 1984, ten patients were interviewed and examined in order to obtain a consistent clinical data base, including demographic information, past illnesses, number of sexual contacts, and prior antibiotic use. Routine laboratory studies were obtained including hepatitis B markers, immunoglobulins, and antigen skin testing. Three of the ten met the CDC's case definition for AIDS.[7] The remaining seven patients were grouped together as having prodromal syndromes of AIDS. One of these patients had the syndrome of AIDS related complex (ARC), defined as the pres-

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Table 1: *Clinical and laboratory findings*

CASE NO.	AGE (yrs)	NO. OF CONTACTS*	CLINICAL DIAGNOSES†	SUBSET RATIOS‡	OTHER LAB DATA§	DIAGNOSTIC CATEGORY‖
1	40	> 100	*Pneumocystis carinii* pneumonia Cytomegalovirus colitis Disseminated herpes zoster Possible tuberculous meningitis	0.25	Anergic Elevated immunoglobulins HBcAb+, Reactive lymphnode	AIDS
2	33	> 100	*Pneumocystis carinii* pneumonia *Mycobacterium avium-intracellulare* and cytomegalovirus duodenitis Perirectal herpes simplex	0.30	Anergic HBsAg−, HBsAb+, HBcAb+	AIDS
3	31	< 50	*Pneumocystis carinii* pneumonia Candidal esophagitis	0.51	Anergic Elevated immunoglobulins HBsAg−, HBsAb+, HBcAb+	AIDS
4	29	>2000	Fever, diarrhea, adenopathy, weight loss, fatigue	0.36	Anergic HBsAg−, HBsAb−, HBcAb+ Reactive lymphnode	ARC
5	30	>1500	Adenopathy, fatigue, hepatosplenomegaly	0.60	Anergic Elevated immunoglobulins HBsAg−, HBsAb+, HBcAb+	LAS
6	25	< 50	Adenopathy	0.45	Elevated immunoglobulins Normal skin testing HBsAg−, HBsAb−, HBcAb− Reactive lymphnode	LAS
7	28	< 100	Mycoplasma pneumonia with respiratory failure	0.70	Normal	SC
8	27	> 100	Disseminated atypical mycobacteriosis	1.2	Normal skin testing HBsAg−, HBsAb+, HBcAb+	SC
9	22	< 10	Recurrent localized herpes zoster	1.3	Normal	SC
10	39	>1500	Intermittent adenopathy	2.3	Normal skin testing Elevated immunoglobulins HBsAg−, HBsAb+, HBcAb+	SC

*Number of life-time sexual contacts.
†Specific conditions frequently associated with AIDS (see text).
‡T-lymphocyte subset ratios (OKT4/OKT8).
§HBsAg = Hepatitis B surface antigen; HBsAb = Hepatitis B surface antibody; HBcAb = Hepatitis B core antibody.
‖See text for definitions.

ence of two or more clinical signs (fever, lymphadenopathy, diarrhea, fatigue, night sweats, or weight loss) plus two or more laboratory abnormalities (reversed helper/suppressor ratios, decreased helper T-lymphocyte count, leukopenia, hypergammaglobulinemia, or decreased proliferative response of lymphocytes to mitogens). Two had persistent generalized lymphadenopathy syndrome (LAS), or lymphadenopathy present for at least three months involving two or more extra-inguinal sites, and four had diseases strongly suggestive of an abnormality in immunity, either because of severity or type of disease, but did not fall into any of the above categories. These were collectively called suggestive cases (SC). The controls were healthy hospital personnel with no known underlying immunodeficiency.

Immunologic studies. Peripheral T-lymphocyte subsets were determined using monoclonal antibodies to helper (OKT4) and suppressor (OKT8) cells as previously described.[8] Circulating IgG antibodies to cytomegalovirus (CMV) and herpes simplex types 1 and 2 (HSV-1, HSV-2) were measured using a commercially available enzyme-linked immunosorbent assay (ELISA), (M.A. Bioproducts, Walkersville, MD).

Mononuclear cells were obtained from heparinized venous blood; lymphocyte proliferation activity was measured after incubation with phytohemagglutinin (PHA), staphylococcal enterotoxin B (SEB), HSV-1, CMV and varicella zoster (VZ) using [^{3}H]-thymidine incorporation.[9]

Interferon production by lymphocytes after exposure to mitogens (PHA, SEB) and antigens (HSV-1, CMV, VZ) and measurement of circulating interferon from patients' serum was

determined by an encephalomyocarditis virus hemagglutination yield-reduction assay using WISH cells.[10]

Statistical analysis. For each study group (AIDS, prodromal AIDS, normal controls), geometric means were compared using one-way analysis of variance, and multiple comparisons were performed with the least significant difference test.[11]

RESULTS

Clinical features. All ten study patients were male homosexuals between 22 and 40 years of age (Table 1). One patient (patient 5) also had a history of intravenous drug abuse. All patients had been treated with various antibiotics and six have had multiple episodes of sexually transmitted diseases (data not shown). All three AIDS patients developed *Pneumocystis carinii* pneumonia and had evidence of other opportunistic infections as well. Two of these patients have died from overwhelming infections. None has developed Kaposi's sarcoma or other malignancies. The remaining seven patients have had several clinical syndromes (Table 1). All AIDS patients, the patient with ARC, and one patient with LAS were anergic on multiple antigen skin testing and seven had evidence of prior hepatitis B virus infection.

One patient originally followed with LAS (patient 5) has recently developed AIDS. He has been found to have *Pneumocystis carinii* pneumonia and nephrotic syndrome. Of the other patients in the prodromal group, none has developed AIDS.

Lymphocyte subsets. Two AIDS patients and one patient with LAS had peripheral white blood cell counts less than 4,000 per cu mm. All AIDS patients and four patients with prodromal syndromes had decreased numbers of helper T-lymphocytes with helper/suppressor ratios (OKT4/OKT8) less than 1.0. The range for normal controls was between 1.3 and 1.7 (Table 1).

IgG antibody determination. The ten study patients generally had higher levels of IgG antibodies as determined by ELISA than normal controls, particularly to CMV (mean absorbance value 0.87 $\pm$0.32 for study patients versus 0.24 $\pm$0.31 for controls, $p<0.01$ and HSV-2 (0.90 $\pm$0.49 for study patients versus 0.34 $\pm$0.30 for controls, $p<0.01$) indicating more frequent exposure to these agents. Antibody levels to HSV-1 tended to be low in the study patients and controls (0.57 versus 0.36, $p>0.05$). There were no significant differences between AIDS patients and patients with prodromal syndromes for any of the antibodies tested.

Lymphocyte proliferation activity. Lymphocyte proliferation response to mitogens and microbial antigens was significantly impaired in the three AIDS patients and in several of the patients with prodromal syndromes as compared with controls. The differences were generally greater for antigen peak responses (data available on request).

Interferon production and circulating interferon. In response to PHA and SEB, lymphocytes from two AIDS patients produced no IFN, and only small amounts were produced by cells from the third patient (data available on request). No IFN was produced by lymphocytes from the AIDS patients exposed to antigens HSV-1, CMV, and VZ. Prodromal AIDS group and normal controls did not differ in IFN response to mitogens or antigens. Of interest, all three AIDS patients had detectable amounts of circulating IFN in their serum whereas none of the other study patients or controls had IFN present. Patient 5 did not have IFN present in his serum when first studied in the group of LAS patients. He has subsequently developed AIDS with *Pneumocystis carinii* pneumonia

Table 2: *Characterization of interferon*

SOURCE OF INTERFERON	PATIENT NO.	ANTIVIRAL ACTIVITY: TITER ON HUMAN CELLS (IU/ml)	ANTIVIRAL ACTIVITY: TITER ON HUMAN CELLS/TITER ON BOVINE CELLS	NEUTRALIZATION FACTOR*: ANTIBODY TO IFN-α	NEUTRALIZATION FACTOR*: ANTIBODY TO IFN-β	NEUTRALIZATION FACTOR*: ANTIBODY TO IFN-γ	INACTIVATION FACTOR†: pH 2	INACTIVATION FACTOR†: 56 C
Patient's Serum	1	25	<1	≥10	1	1	21	21
	2	98	<1	58	1	1	2	82
	3	48	<1	20	1	1	40	40
	5‡	25	<1	40	4	4	2	21
IFN Standards§								
IFN-α		5,000	<1	42	1	1	1	1
IFN-β		2,100	1	1	42	1–2	1	3,500
IFN-γ		1,680	2,800	1–2	1–2	50	2,800	2,800

*Neutralization factor = Titer of IFN in medium controls/titer of IFN plus antibody. A neutralization factor of 1 denotes no neutralization.
†Inactivation factor = Titer of IFN in control samples/titer in samples incubated at pH 2 for 24 hours, or 56 C for 1 hour. An inactivation factor of 1 denotes no inactivation.
‡Patient 5 studied after the development of AIDS (see text).
§The source of IFN standards and antibodies to IFN-α and IFN-β was the NIH. The source of antibodies to IFN-γ was the Meloy Corporation.

and on repeat testing, his serum demonstrated measurable circulating IFN-α (Table 2).

Interferon characterization. To further characterize the circulating IFN found in the three AIDS patients and patient 5 (after developing AIDS), we performed neutralization studies according to the method of Preble, et al.[12] As seen in Table 2, IFN in serum of all four patients with AIDS fulfilled the characteristics of acid labile IFN-α as described previously in sera of patients with AIDS by DeStefano, et al.[6] Specifically, its activity in human and bovine cells was approximately equal, it was neutralized by anti-IFN-α antibody, and it was inactivated at pH 2 (unusual for IFN-α). In addition, the IFN was heat labile at 56 C for 60 minutes, and as such is similar to IFN-α reported by Preble in patients with systemic lupus erythematosus.[12] Since none of the patients with AIDS prodrome or normal control subjects had demonstrated serum IFN activity in our study, this acid-labile IFN-α appears to be a useful marker of AIDS.

Interferon produced in response to mitogens and viral antigens was interferon gamma (IFN-γ) in that it was more active in human than bovine cells, was inactivated by anti-IFN-γ antibodies, and was pH 2 and heat labile (data not shown).

DISCUSSION

Three patients with AIDS and seven patients with ARC, LAS, or syndromes suggestive of impaired cellular immunity (SC) were seen in Milwaukee during 1983-1984. As is characteristic of such patients elsewhere, all were male homosexuals; and while the three AIDS patients developed multiple opportunistic infections, there were no differences among the study patients with regard to number of sexual partners, prior sexually transmitted diseases or antibiotic usage, prior hepatitis B infections or other clinical findings.

The results in our study indicate that both AIDS patients and those with prodromal syndromes had abnormalities of the immune system. Most of the patients in both groups had abnormal T-lymphocyte ratios and abnormal peripheral leukocyte counts as compared to normal controls. AIDS patients demonstrated a decrease in lymphocyte proliferation to mitogens and antigens. The most striking difference, however, between the AIDS group and the other patients and controls was the absence of IFN-γ production by lymphocytes in response to herpesvirus antigen stimulation and the presence of an unusual circulating IFN-α in the serum of the former group.

Other investigators have shown similar findings. Murray, et al[13] found impaired IFN-γ production in 11 of 16 AIDS patients in response to mitogens and 14 of 14 in response to microbial antigens. DeStefano, et al[6] found acid-labile IFN-α in the serum of 63% of male homosexuals with AIDS and Kaposi's sarcoma but in only 29% of homosexuals with lymphadenopathy and in none of 22 normal controls. Eyester[5] has demonstrated the presence of acid-labile IFN-α in hemophilia patients with AIDS, two of whom developed circulating IFN-α 3 to 10 months prior to the appearance of opportunistic infections. Hooks, et al detected circulating IFN-α in 80% of AIDS patients and observed deficient IFN-γ production in cells from 9 of 10 of these patients (unpublished observations). Other studies support these findings.[14,15]

It is well known that interferons are involved in immunoregulation.[16] Interferons augment activity of natural-killer cells and T-lymphocyte cytotoxicity[17,18] and play a pivotal role in activating the antimicrobial mechanisms of macrophages and inducing the release of other lymphokines.[19] Interferons have also been shown to impair the immune response.[20] It is possible that several of the immune derangements leading to impaired cellular immunity in AIDS patients are related to a decreased production of IFN-γ by lymphocytes in response to a microbial antigen. The relatively high levels of circulating IFN-α found in the serum of AIDS patients may also play a role in immunosuppression. Further studies are needed to elucidate the role(s) of IFN in the pathogenesis of AIDS. Since this unusual IFN-α has been found in the blood of AIDS patients in our study and in homosexuals with prodromal syndromes reported by other investigators, acid-labile IFN-α serves as a possible marker for AIDS and may play a role with other interferons in the impairment of immunity found in these patients.

Addendum. As of January 1985, thirty (30) cases of AIDS have been reported to the State Health Department in Madison (H Dowling, personal communication). Sixteen of these cases have been acquired within the state of Wisconsin, while the remainder have been acquired in other cities. Eighteen of the 30 patients are dead. Besides the four cases reported here, we have seen an additional seven cases of AIDS at the Medical College of Wisconsin (three of whom are still alive) and are following 12 patients with prodromal findings of AIDS.

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REFERENCES available upon request to the authors.■

SMS Annual Meeting focuses on critical medical issues

From start to finish, the State Medical Society of Wisconsin's Annual Meeting this year will be sharply focused on the issues most important to the practice of medicine in the mid-1980s. Physicians attending will have excellent opportunities to learn, listen, and debate at this major meeting of the year.

The 1985 Annual Meeting, to which all SMS members are invited, will take place Thursday, April 25, through Saturday, April 27, at the La Crosse Center and Radisson La Crosse Hotel.

The theme for the meeting is "Cost-effective Care of the Geriatric Population." This three-part program will examine economic and ethical considerations of rationing geriatric care. The final part of the series will look at the prevention and treatment of osteoporosis.

A diversified scientific program sponsored by specialty sections and societies will cover a wide set of medical interests on Friday and Saturday, April 26 and 27. These programs offer Category I Continuing Medical Education credit.

The SMS House of Delegates will begin its annual deliberations at 9:00 am Thursday, April 25, at the La Crosse Center. Resolutions to be presented to the entire House for action will be debated at reference committee sessions following the opening House session Thursday at 1:00 pm at the Radisson La Crosse Hotel. (A listing of resolution summaries is contained in the March 13 issue of MEDIGRAM and also this issue of the *Wisconsin Medical Journal.*) The second session of the House will begin at 1:45 pm.

"Drugs and the Geriatric Population—A Masquerade" will be discussed at a special panel presentation on Thursday, April 25, at 12 noon. The program will feature physician experts in the fields of geriatrics and addictive diseases.

Thursday evening, April 25, SMS President Timothy Flaherty, MD and Auxiliary President Roberta Baldwin invite physicians and their spouses to attend the Presidents' Dinner at the Radisson La Crosse. Featured entertainment will be the La Crosse Singers performing "The Best of Broadway—A Revue." The fast-paced show incorporates "The Best" in musical theatre music, ranging from the early 1900s through the 1980s. With such musical theatre greats as: Porter, Gershwin, Sondheim, Loesser, Rodgers and Hammerstein, and Herbert, the musical revue is guaranteed to delight and entertain.

"A Native American View of Medicine and Religion" is the title of this year's program at the Medicine and Religion Breakfast at 7:00 am, Friday, April 26. The featured speaker will be the Rev Gary Turner of the Episcopal Diocese of Eau Claire.

Later Friday at 11:45 am is the Socioeconomic Luncheon sponsored by WISPAC. *Washington Post* columnist Mark Shields will be on hand to discuss "Presidential Politics: 1984 and Beyond." A political analyst who has covered elections for both CBS and NBC, Shields has been described as a "walking almanac of American politics." ■

Dr Pomainville resigns CESF treasurer post

After nearly 18 years of service as treasurer of the Charitable, Educational and Scientific Foundation, Leland Pomainville, MD, Wisconsin Rapids, has announced his resignation. Elected to fill the unexpired term of treasurer is Richard Edwards, MD, Richland Center. Doctor Edwards is currently chairman of the Foundation's Managing Committee for the Fort Crawford Medical Museum. ■

Biomedical ethics conference coming up June 6 and 7

The State Medical Society and the Wisconsin Hospital Association are sponsoring a Biomedical Ethics Conference for physicians and hospital administrators on June 6 and 7, 1985 at the American Club in Kohler, Wisconsin. The conference will examine topics such as "How does rationing affect the ethics of medical care decision-making?" and "Medical Ethics and the Media." Nationally noted speakers will be featured including: Dr William Schwartz, coauthor of *The Painful Prescription* and Dr Joanne Lynn, staff to the President's Commission on Bioethical Decision-making. This promises to be an important and timely program for physicians in all specialties. Members will be receiving registration materials soon. For further information contact Michelle Scoville at SMS. ■

ANNUAL MEETING

Professional liability, emergency medical services, and government regulations are key issues for '85 House of Delegates

The House of Delegates will consider resolutions ranging in subject matter from professional liability and emergency medical services to government regulations when it convenes at the State Medical Society's Annual Meeting in La Crosse April 25-27.

The following resolutions were received in the Secretary's office by the February 25 deadline. Members are urged to express their opinions to their delegates and participate at the Annual Meeting Reference Committee hearings where resolutions are discussed. A list of county medical society officers appeared in the February issue and a list of delegates and alternate delegates appeared in the March issue.

Members are reminded that the first session of the House will start at 9:00 am Thursday, April 25, with the second and third sessions scheduled for 1:45 pm Friday, April 26. Registration precedes both sessions.

Resolutions 1-5 referred to: National Issues

1. Federal nursing home code (Lincoln County Medical Society)

"Whereas, Rigid interpretation of obscure and petty regulations, especially when surveys are conducted in the spirit of an adversary examination, threatens the nursing home, its administration, and the nursing staff . . .

"RESOLVED, That the State Medical Society of Wisconsin request the American Medical Association to approach the Federal Government toward a reevaluation of the rules and enforcement mechanisms for nursing homes, in conjunction with medical and nursing home representation."

2. Health care banks/IRAs (Medical Society of Milwaukee County)

"Whereas, The Health Care Banks/IRA concept is a method of providing health care coverage by private savings . . .

"RESOLVED, That SMS support the Health Care Banks/IRA concept and seek more information about such a concept and the logistical problems associated with it and submit a report to the House of Delegates on its advantages and disadvantages."

3. Reduction of nuclear armaments (Committee on Environmental and Occupational Health)

"Whereas, the risk of nuclear war in our lifetime is considerable (consistent with 5.8 percent annual risk of major war); and

"Whereas, the State Medical Society of Wisconsin is fully committed to prevention of death and disease and the promotion of public health . . .

"RESOLVED, That the State Medical Society of Wisconsin hereby proposes that the United States of America and the Union of Soviet Socialist Republics reduce nuclear armaments;

"RESOLVED, That the United States of America and the Union of Soviet Socialist Republics seek to increase communication between their governments in respect to nuclear armaments;

"RESOLVED, That they formulate a more comprehensive, verifiable nuclear test ban treaty and an effective worldwide policy of nonproliferation of nuclear armaments."

4. Safe transport of hazardous materials (Committee on Environmental and Occupational Health)

"Whereas, the State Medical Society's Committee on Environmental and Occupational Health has concluded that a sufficient number of hospitals is not prepared to treat radiologically contaminated patients due to an accident, that voluntary participation by additional hospitals is inadequate to assure safe treatment, and that voluntary participation is not practical or cost-effective . . .

"RESOLVED, That the State Medical Society encourage the enactment of legislation which will clearly designate state departmental responsibility to assure hospital preparedness to safely treat radiologically contaminated patients in the event of a minor spent fuel accident while protecting other patients, hospital personnel, and the public from contamination and, in the interim that the Governor direct state officials to assure preparedness by identifying hospitals located ideally 40-50 miles from each

other along shipment routes, train personnel in the use of the Radiation Accident Protocol, provide funds for equipping these hospitals, and periodically conduct emergency drills to assure continued preparedness;

"RESOLVED, That the State Medical Society encourage the state Legislature to initiate a study of hazardous materials transport in Wisconsin and enact appropriate legislation to assure hospital preparedness to respond to accidents in a manner which protects the public."

5. Cost containment at AMA functions (Carl Eisenberg, MD, Alternate Delegate, Milwaukee County)

"Whereas, We as members of the American Medical Association are concerned about the cost of our memberships . . .

"RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin instruct the Wisconsin AMA Delegation to pursue a resolution within the AMA which would have as its effect the emphasizing of cost containment at every possible AMA function."

Resolutions 6-8 referred to: Organization and Finances

6. Unified membership (Waukesha County) Medical Society)

"Whereas, The AMA (Report DD-1984 Interim Meeting) has now offered incentives to unified membership, *ie,*

"*Recommendation 1:* Commendation to unified state, county and specialty societies.

"*Recommendation 2:* That the AMA establish an 'ombudsman' for members of unified societies.

"*Recommendation 3:* That 1st year in practice, 2nd year in practice, military, and full dues-paying AMA members who are members of unified societies receive *a 10% discount on AMA dues,* effective for the 1985 membership year.

"*Recommendation 4:* That the AMA provide unified state societies with reimbursement for collection of AMA dues at a rate of 3% of dues received by January 15, 2.5% of dues received by February 15, and 2.0% of dues received by March 15 of each year, beginning in 1985.

"*Recommendation 5:* That, effective immediately, the AMA extend to unified societies the services of its staff on special projects which are mutually agreeable to the unified society and the AMA, within the limits of staff and resource availability.

"*Recommendation 6:* That no later than February 1985, the AMA establish a new Unified Societies Advisory Committee consisting of representatives from all unified societies.

"*Recommendation 7:* That, beginning in 1985, a special AMA briefing be provided annually to the officers of unified societies.

"*Recommendation 8:* That a summary of the benefits accruing to unified medical societies be sent to all state, county, and national medical specialty societies in the United States, and that the same information be disseminated to all members of unified medical societies . . .

"RESOLVED, That the State Medical Society of Wisconsin again become a unified state."

7. Establishment of Section on Therapeutic Radiology [Radiation Oncology] (Duane W Taebel, MD)

"Whereas, Therapeutic Radiology (Radiation Oncology) is recognized as a distinct discipline, separate from Diagnostic Radiology, and requiring a completely different examination for certification by the American Board of Radiology; and

"Whereas, More than one-half of all medical schools in the United States have formed departments of Therapeutic Radiology (Radiation Oncology), separate and distinct from departments of Diagnostic Radiology . . .

"RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin establish a specialty Section on Therapeutic Radiology (Radiation Oncology) and that a delegate and alternate delegate to the House of Delegates be elected by the SMS members of that group acting as a section of the State Medical Society."

8. Establishment of Section on Gastroenterology (Wisconsin Society of Gastrointestinal Endoscopy)

"Whereas, The American Medical Association has recognized the specialty of Gastroenterology with three representatives in the House of Delegates. These delegates represent the American Society for Gastrointestinal Endoscopy, the American Gastroenterological Association, and the American College of Gastroenterology. Members of these organizations include both medical gastroenterologists and surgeons interested in gastrointestinal diseases . . .

"RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin establish a specialty Section on Gastroenterology and that a delegate and alternate delegate to the House of Delegates be elected by the SMS

members of that group acting as a section of the State Medical Society."

Resolutions 9-16 referred to: Scientific Activities

9. Boxing (La Crosse County Medical Society)

"Whereas, The medical profession has an obligation to promote and encourage the health and well-being of the American population . . .

"RESOLVED, That the State Medical Society of Wisconsin

1) Educate the public concerning the dangerous aspects of boxing.
2) Insist on closer medical supervision of boxing bouts, both amateur and professional, now being held in the confines of Wisconsin.
3) Encourage the state legislature to enact laws to insure closer medical supervision of boxing and/or the elimination of boxing."

10. Boxing (Section on Family Practice)

"Whereas, The risks of boxing to its participants far outweigh any benefits . . .

"RESOLVED, That the State Medical Society of Wisconsin reaffirm its opposition to boxing to the media and inform the Governor of Wisconsin and all members of the State Legislature of its stand; and be it further

"RESOLVED, That the Society through elected representatives introduce legislation supporting the abolition of amateur and professional boxing in the state of Wisconsin."

11. Boxing (Committee on School Health)

"Whereas, Existing medical controls and safety measures have not been successful in preventing chronic brain damage in boxers . . .

"RESOLVED, That the State Medical Society of Wisconsin encourage the elimination of boxing at the amateur and professional level in Wisconsin."

12. Smokeless tobacco (Medical Society of Milwaukee County)

"Whereas, The American Medical Association plans to evaluate scientific evidence on '. . . the possible carcinogenic and other deleterious effects resulting from the use of smokeless tobacco' . . .

"RESOLVED, That SMS review the recommendations and, if the report shows conclusively that smokeless tobacco is harmful to one's health, that SMS support the placement of an appropriate 'injurious to health' message on the smokeless tobacco package."

13. Happy hours and other inducements to the consumption of alcohol (La Crosse County Medical Society)

"RESOLVED, That the State Medical Society of Wisconsin encourage the legislature to enact laws which would prohibit drinking establishments from offering inducements to excessive alcohol consumption."

14. Mandatory continuing medical education (Medical Society of Milwaukee County)

"Whereas, Continuing medical education is a mandatory program for physicians in Wisconsin . . .

"RESOLVED, That SMS continue its support of such a requirement."

15. Medical Examining Board (Medical Society of Milwaukee County)

"Whereas, The Wisconsin Medical Examining Board requires additional funds to expand its staff in order to provide competent trained investigators . . .

"RESOLVED, That SMS support adequate funding for the Medical Examining Board to fulfill its responsibility; and be it further

"RESOLVED, That the assistance of SMS be offered for consultation purposes whenever questions of incompetence arise and that specialty societies in the state of Wisconsin be asked to cooperate in like manner."

16. Home health agencies (Medical Society of Milwaukee County)

"RESOLVED, That SMS invite representatives of the Home Health Care Association, Wisconsin Nurses Association, and the Wisconsin Hospital Association to explore and establish minimum criteria for an effective quality assessment and quality control program for home health care agencies in Wisconsin."

Resolutions 17-27 referred to: Socioeconomic Activities

17. Professional liability [Expert witnesses] (La Crosse County Medical Society)

"RESOLVED, That the State Medical Society of Wisconsin continue its efforts to maintain the requirement for expert witnesses at panel hearings . . .

"RESOLVED, That a joint State Medical Society-Wisconsin Bar Association committee establish criteria to qualify physicians as experts for purposes of testimony in a particular field."

18. Professional liability [physician countersuits] (Waukesha County Medical Society)

"Whereas, The frequency of professional liability claims against physicians continues to escalate; and

"Whereas, In Wisconsin (one of 15 states) it is impossible to win a countersuit under malicious prosecution because of a fifth element of 'special injury' (interference with one's person or property) . . .

"RESOLVED, That the State Medical Society of Wisconsin support the principle that the 'special injury' element required to win a malicious prosecution countersuit in Wisconsin be eliminated; and be it further

"RESOLVED, That legislation be pursued as early as possible to correct this element in the Wisconsin tort system."

19. Professional liability [countersuits] (Medical Society of Milwaukee County)

"Whereas, The American Medical Association plans to draft model legislation to eliminate 'special injury' as a requirement in malicious prosecution suits; and

"Whereas, The principle of 'special injury' is a requirement in Wisconsin . . .

"RESOLVED, That SMS acquire and study the model legislation and, after study of it, prepare and introduce similar legislation to the State Legislature to eliminate this requirement in Wisconsin."

20. Professional liability International Scope Study (Carl Eisenberg, MD, Alternate Delegate, Milwaukee County)

"RESOLVED, That the State Medical Society of Wisconsin through its Medical Liability Committee undertake a study of how the liability situation is handled on an international scope to include, but not be limited to, English speaking countries."

21. Appeal and monitoring mechanism for patients and their physicians (Polk County Medical Society)

"RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin request the Board of Directors and staff to study and, if found feasible, to establish an appeal and monitoring mechanism for patients and their physicians when fair and equal access to adequate health care is denied or restricted by a governmental regulatory body, a health maintenance organization, or health insurance company."

22. Emergency Department reimbursement for treatment of HMO/AFDC patients (Emergency Medical Services Committee, Medical Society of Milwaukee County)

The Department of Health and Social Services is attempting to contain medical costs generated by AFDC recipients in Milwaukee and Dane Counties by mandating these citizens enrollment in Health Maintenance Organizations. The administration rules used in this effort place the hospital's emergency medical physician in conflict with a state statute, place the patient in an increased category of medical risk, and the hospital in increased financial jeopardy.

"Whereas, Wisconsin Statutes 146.301 (2) and (3) state: "(2) No hospital providing emergency services may refuse emergency treatment to any sick or injured person; (3) No hospital providing emergency services may delay emergency treatment to a sick or injured person until credit checks, financial information forms or promissory notes have been initiated, completed or signed if, in the opinion of one of the following, who is an employee, agent or staff member of the hospital, the delay is likely to cause increased medical complications, permanent disability, or death:" and

"Whereas, Emergency medical physicians cannot determine if a patient presenting himself in a hospital emergency department has a true medical emergency until that person is evaluated by the physician at a cost of time and materials to the hospital; and

"Whereas, Contracts signed between the DHSS and Milwaukee County HMOs for the treatment of AFDC Title 19 recipients direct the patient to receive care at his or her assigned HMO facility unless, 'The time (needed) to get to the HMO facilities or providers would risk permanent damage to (the patient's) health'*; and

"Whereas, There are numerous medical situations in which no individual can reasonably be expected to know if symptoms are a permanent threat to his or her health; and

*From "Standard Language" definitions employed by the DHSS for HMO/AFDC contracts.

"Whereas, Hospitals which refuse to evaluate an AFDC/HMO patient until preauthorization is received from the patient's HMO place themselves in a greatly increased risk of liability; and

"Whereas, AFDC patients have historically used hospital emergency departments as their gatekeepers to the healthcare system; and

"Whereas, the DHSS contract with HMOs for the care of AFDC patients provides no incentives for the HMO or patient to change this pattern of behavior; and

"Whereas, DHSS contract language uses a retrospective definition of emergency . . .

"RESOLVED, That the House of Delegates of the State Medical Society be on record as opposing any attempt to modify Wisconsin Statutes 146.301 in any effort to correct the dilemma described in this resolution; and that it be known that this opposition is based on the highest standards of professional medical ethics; and be it further

"RESOLVED, That the House of Delegates of the SMS direct staff to negotiate with the DHSS to have the definition of Bona Fide Medical Emergency, as printed in the June 22, 1984 Congressional Record (copied below), accepted by the American College of Emergency Physicians and the Health Care Financing Administration, adopted by the department as its definition of emergency for AFDC/HMO patients; and be it further

"RESOLVED, That the DHSS enter into contractual arrangements with hospital emergency departments in areas of the state where there exist contracts with HMOs for the care of AFDC patients; that these contracts between the DHSS and hospital emergency departments provide a payment schedule for the evaluation of AFDC patients who present themselves; and be it further

"RESOLVED, That the SMS is cognizant of the state's desire to reduce its Medicaid costs by decreasing utilization of health care services by AFDC patients."

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Definition of Bona Fide Emergency Services[8]

Sec. 2318. (a) Section 1861 (v) (1) (K) of the Social Security Act is amended by inserting "(i)" after "(K)" and by adding at the end thereof the following new clause:

"(ii) For purposes of clause (i), the term 'bona fide emergency services' means services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(I) placing the patient's health in serious jeopardy;

"(II) serious impairment to bodily functions; or

"(III) serious dysfunction of any bodily organ or part."

[8]"As published in the June 22, 1984 *Congressional Record—House.*

23. Repeal of Certificate-of-Need/Capital Expenditure Review Law (Medical Society of Milwaukee County)

"Whereas, The Certificate of Need (CON) law was enacted to prevent duplication of health care services and constraining construction of new health care facilities; and

"Whereas, Prospective rate review, capitalization controls, and competition in the health care marketplace would appear to eliminate any continuing need for CON . . .

"RESOLVED, That the SMS review and evaluate current studies that question the ability of CON to contain costs and present the results of such a review to the Legislature to bring about the repeal of this law."

24. Mandatory surgical second opinion (Medical Society of Milwaukee County)

"Whereas, The Wisconsin Department of Health and Social Services has mandated a second surgical opinion program for select operations on Medicaid patients; and

"Whereas, *The Center for Health Systems Research and Analysis of the University of Wisconsin has a study approved by DHSS* . . .

"RESOLVED, That SMS urge the Secretary of the Department of Health and Social Services to fund this study."

25. Decentralization of health care (Medical Society of Milwaukee County)

"Whereas, Little data is available on the cost of decentralization of health care; and

"Whereas, Such decentralization is being developed rapidly through the introduction of home health care agencies, surgi-centers, and emergi-centers . . .

"RESOLVED, That the Task Force on Medical Care of SMS study the cost of decentralization of health care in Wisconsin and report back to the House of Delegates."

26. HMOs and physician input (Medical Society of Milwaukee County)

"Whereas, The citizens of Wisconsin are served by many Health Maintenance Organizations and other new health care delivery systems; and

"Whereas, These systems include delivery of physician services, reimbursement of physicians, quality control, utlization review, and other physician services . . .

"RESOLVED, That SMS promote physician input into these systems and also consider the establishment of a unit within the Society for physicians to contact for advice and counsel regarding these new systems."

27. WiPRO (Medical Society of Milwaukee County)

"Whereas, Organized Medicine in Wisconsin is concerned about the activities of WiPRO and their impact upon the practice of medicine and the quality of care for patients; and

"Whereas, No mechanism exists in organized medicine to monitor WiPRO's activities . . .

"RESOLVED, That SMS create such a mechanism within the State Medical Society with representation from county medical societies, and require such a monitoring group to submit an annual assessment of WiPRO and its activities and recommendations for consideration by the SMS House of Delegates and the general membership."■

SMS Toll-free
number in Wisconsin
1-800-362-9080

Have you paid your 1985 membership dues?

Final dues statements were sent in mid-April. Regular member dues of $455 must be paid in full no later than May 15, 1985 to continue as a member. See further details on page 34.

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

JANUARY 1985

*Algan, Ahmet M, Madison
*Arvold, David S, Shawano
*Austad, William R, Monroe
*Benish, George A, Madison
*Bogost, Bruce R, Milwaukee
*Chou, Clarence P, Whitefish Bay
*De Arteaga, Julio C, Brillion
*Forkner, William A, Kohler
*Fritz, Richard D, Milwaukee
Glazier, Edward H, Wautoma
Gokulananda, Thimapalah, Brookfield
*Goldberg, Henry M, Milwaukee
Hahn, Michael F, Janesville
*Janssen, Martin L, Friendship
Jones, Ethelene J C, Milwaukee
Kampschroer, Bernard H, Milwaukee
*Ketterhagen, James P, Wauwatosa
Kochar, Arvind, Elkhorn
*Kochar, Mahendra S, Milwaukee
*Kutter, Ursula Anna-Maria, Milwaukee
*Lewan, Richard B, Waukesha
Liedtke, Arthur J, Madison
*Lubing, Harold N, Madison
*Martinetti, Dominic J, Hurley
*Maski, Ravikant, Platteville
*Page, Robert W, Marshfield
*Pagels, George A, Marshfield
Patel, Piyush D, West Allis
*Piper, Philip G, Janesville
Pratt, Craig T, Glendale
*Reinhart, Richard A, Marshfield
Roth, Donald A, Brookfield
*Scheibel, William R, Verona
*Semler, William L, Milwaukee
*Settimi, Albino L, Elm Grove
*Shehab, Naglaa, Marshfield
Shetty, K Rajmohan, Wood
*Stoerker, Ruth A, Madison
Thomas, John P, Wauwatosa
*Todd, Paul C, Menomonee Falls
*Troup, Richard H, Green Bay
*Wegenke, John D, Madison
Weinman, Mary S, Madison
*Willson, D Maclean, Milwaukee
*Winston, Frank, Madison
*Wynn, Sidney K, Milwaukee
*Young, Laurens D, Milwaukee
*Yuska, Kenneth H, Marinette

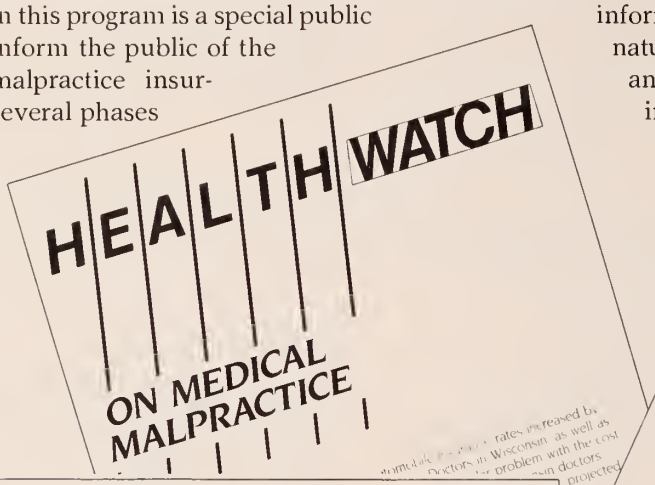
FEBRUARY 1985

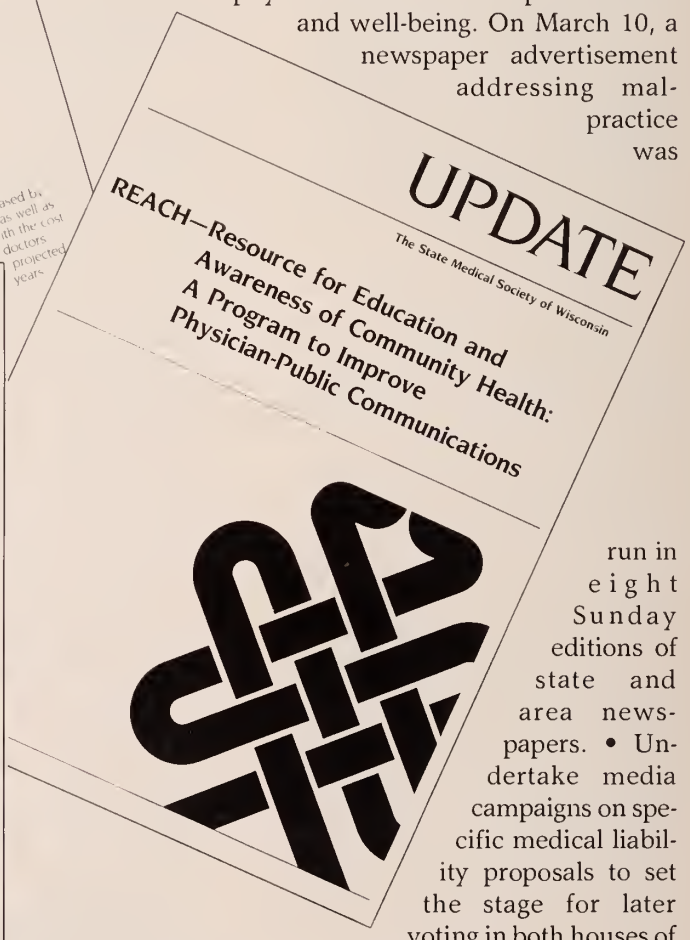
*Biros, Dennis G, La Crosse
*Budzak, Kathryn S, Madison
Dhamee, Mohammed S, Milwaukee
Divgi, Ajit B, New Berlin
*Engstrom, Denton P, Appleton
*Flygt, Thomas R, Baraboo
*Francisco, Orlando M, Tomahawk
Glazier, Edward H, Wautoma
Hartwick, John P, Wauwatosa
Hecht, Rudolph C, Madison
*Hyndiuk, Robert A, Milwaukee
*Kelley, William B, Milwaukee
Kolesari, Gary L, Milwaukee
Laird, Anna K, Madison
Magnino, James J, Kenosha
*March, Jack F, Algoma
*Melvin, John L, Milwaukee
*Nordby, Eugene J, Madison
*Reinhard, Harold J, Green Bay
*Rounds, Wayne M, Madison
*Sazama, Richard C, Eau Claire
Schulz, Robert W, Stoughton
*Sherkow, Larry H, Milwaukee
*Short, Howard W, Racine
*Stemper, John A, Milwaukee
*Tsuchiya, Goro, Racine
*Turski, Deborah M, Madison
*Wepfer, Joseph F, Wauwatosa
Wilson, Stuart D, Milwaukee
*Wunsch, Charles A, Milwaukee■

*Members of the State Medical Society of Wisconsin

SMS launches campaign to improve communications

THE STATE MEDICAL SOCIETY OF WISCONSIN is implementing a special program in 1985 to improve communications between physicians and the public. REACH—Resource for Education and Awareness of Community Health is designed to go beyond current SMS public relations activities. The new program will "tell medicine's story" on the professional liability issue, alcohol abuse, and a broad array of socioeconomic issues. The first step in this program is a special public information program on medical liability. The goal is to inform the public of the nature of the problem to seek their support for reducing malpractice insurance costs. The Medical Liability program consists of several phases including: • Purchase media advertisements designed to tell the story of medical progress and what the application of those advances by physicians means to the public health and well-being. On March 10, a newspaper advertisement addressing malpractice was run in eight Sunday editions of state and area newspapers. • Undertake media campaigns on specific medical liability proposals to set the stage for later voting in both houses of the Legislature. • Prepare and distribute special literature on the medical liability problem and SMS proposals for solution. This includes an UPDATE on medical liability in Wisconsin as well as a patient brochure explaining the malpractice crisis and how it affects costs. This new brochure, called ***Healthwatch,*** is designed to be used as a handout in physicians' offices or waiting rooms, or as a statement





(continued on next page)

stuffer. ***Healthwatch*** also will be published six times a year on such topics as DRGs, preadmission screening, medical care costs, and health legislation.

• Undertake intensive grass roots physician contacts with legislators on the critical issue of liability and its effects on availability of medical care as well as quality and cost. Special membership mailings will be going out to physicians identifying the issues and requesting legislative contacts.

Other components of the newly-approved REACH program include:

• Increasing public speaking by Society officers who will visit every major media market in Wisconsin in 1985. These media tours will involve prearranged meetings with newspaper editors and TV and radio news directors to discuss organized medicine's concerns on current issues and to communicate personally the desire of SMS to work with media on health and medical stories.

• Syndicating a television health education program produced by family practitioner Alan Cherkasky, MD of Kaukauna. The purpose of these medical news features will be to: (1) educate Wisconsin citizens on how they can lead healthier lives; and (2) to promote the physician as the patient's best source of medical care. Each segment will credit both Doctor Cherkasky and SMS.

• Continuing its production of public service announcements on the dangers of alcohol abuse. The first set of these PSAs, which are produced and distributed in conjunction with the Wisconsin Broadcasters Association, feature well-known Wisconsin athletes discussing responsible alcohol use. Future PSAs on this topic will be aimed specifically at pregnant women discussing fetal alcohol syndrome; parents and their responsibility for educating their children to develop responsible drinking habits; and young adults ages 18-25 pointing out that drinking isn't funny.

• Instituting a speakers bureau in Fall 1985 which will arrange for physician speakers to appear before civic groups, service clubs, and community organizations. The speakers' presentations will focus on socioeconomic issues facing medicine and society as a whole.

The REACH program also emphasizes long-range planning for promoting the public image of physicians. These and other elements of the program are contained in a special UPDATE publication entitled, "REACH—Resource for Education and Awareness of Community Health: A Program to Improve Physician-Public Communications. All SMS members will be receiving a copy of UPDATE in their mail soon. ■

Court halts attempt to get SMS records

After several months of legal action by a Milwaukee plaintiff attorney firm to get SMS records relating to medical liability, Judge Moria Krueger of Dane County Circuit Court has ruled that the Patients Compensation Panel chairperson "abused his discretion" in requesting discovery as urged by the plaintiff attorney. The allegation that SMS records might bear upon the creation of bias among panel members was rejected. The judge said that if the plaintiff attorneys suspect prejudice among panel members, they should conduct a voir dire (questioning) under procedures set forth in the panel law. ■

Child abuse conference May 18 in Madison

Prevention, diagnosis and treatment of child abuse will be the focus of a special conference for physicians the State Medical Society is sponsoring May 18, 1985 at the Sheraton Inn in Madison. Aimed at primary care physicians, the conference will address how physicians can work with county social service/protection agencies in dealing with the diagnosis and treatment of child abuse and neglect victims and perpetrators. For further information, contact Deborah Powers at SMS. ■

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Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1984 Membership Directory as published in the July 1984 issue of the *Wisconsin Medical Journal.* Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership records. County transfers will be included when processing has been completed by the Membership Department.

New, reelected, or reinstated members
(complete information)

Changes in specialties and/or Board certification(*)
(changes only with member's name)

By county medical society

BARRON-WASHBURN-BURNETT

FP*
Borman, Joel A (DO)
Rte 1, Box 146
Cumberland WI 54829

R*
Pelant, Thomas M
113 N Main St
Rice Lake WI 54868

DR R*
Swanson, Richard W
1502 West Marshall
Rice Lake WI 54868

BROWN

HEM IM*
Blank, Jules H
1551 Dousman St
Green Bay WI 54303

IM
Koehler, Thomas P
1751 Deckner Ave
Green Bay WI 54302

U GS
Samuel, David L
1551 Dousman St
Green Bay WI 54303

DANE

OBG
Calhoun, Barbara L
4344 Hillcrest Circle
Madison WI 53705

PD
Ellis, Richard L
3206 Cedar Trail
Middleton WI 53562

Muecke, Maureen
2921 S Fish Hatchery, #102
Madison WI 53713

U
Rodriquez, Paul N
1727 Norman Way
Madison WI 53705

Schwartz, Robert L
1117 Catalpa Circle
Madison WI 53713

FP
Selfridge, Nancy J
1270 West Main St
Sun Prairie WI 53590

IM*
Sheehy, Gregory L
1205 Canterbury Circle
Middleton WI 53562

GE IM*
Yamamoto, Dennis T
20 South Park St, #355
Madison WI 53715

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PO Box 447
Sturgeon Bay WI 54235

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AN
Bowman, Daniel J
727 Kenney Ave
Eau Claire WI 54701

OPH
Lange, Ronald H
2302 Hendrickson Dr
Eau Claire WI 54701

IM GE
Sultan, Michel N
900 W Clairemont Ave
Eau Claire WI 54701

LA CROSSE

FP*
Beyer, Marsha J
815 South 10th St
La Crosse WI 54601

MARINETTE-FLORENCE

PD
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1510 Main St
Marinette WI 59143

MILWAUKEE

Oren, Gideon A
3975 North 68th St
Milwaukee WI 53216

Wisniewski, Peter P
5164 S Mallard Circle
Milwaukee WI 53221

OUTAGAMIE

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Merrick, James G
401 N Oneida St
Appleton WI 54911

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IM* HEM
Beatty, Peter A
1011 North 8th St
Sheboygan WI 53081

FP OBG
Cowan, Karen K
635 Paine St
Kiel WI 53042

U
Fisher, Dirk T
1011 North 8th St
Sheboygan WI 53081

OPH
Green, Kathryn A
1442 North 31st St
Sheboygan WI 53081

WAUKESHA

PD
Biagtan, Juan T
17000 West North Ave
Brookfield WI 53005

PD
De Angelis, Alan A
N84 W1684 Menomonee Ave
Menomonee Falls WI 53051

OBG
Harstad, Timothy W
N84 W16889 Menomonee Ave
Menomonee Falls WI 53051

OBG* END
Katayama, K Paul
725 American Ave
Waukesha WI 53186

N
Shaenboen, Michael J (DO)
W180 N7950 Town Hall
Menomonee Falls WI 53051

FP*
Wiener, Marvin
12500 W Bluemound Rd
Elm Grove WI 53211

PD
Wessling, Mark R
915 East Summit Ave
Oconomowoc WI 53066

WAUPACA

FP*
Dent, Robert A
710 Riverside Dr
Waupaca WI 54981

FP*
Pfarr, Paul A
Box 146
King WI 54946

continued

continued

WOOD

PD* NPM
Gross, Jody R
1000 North Oak Ave
Marshfield WI 54449

County society transfers

FOND DU LAC

(from Outagamie)
Strong, Jeffrey A
229 S Morrison St
Appleton WI 54915

KENOSHA

(from Racine)
Bass Jr, James
6924 Hoods Creek Rd
Franksville WI 53126

OUTAGAMIE

(from Portage)
Harman, Jill P
1830 W Meade St
Appleton WI 54911

PORTAGE

(from Wood)
Paulson, John K
3504 E Maria Dr
Stevens Point WI 54481■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

NOVEMBER 1984

*Adamkiewicz, Joseph J, Milwaukee
Adib, Khosro, Madison
*Ahmad, Muhammad Y, Merrill
*Ancheta, Valentino S, Algoma
Bamrah, Virinderjit S, Wood
*Behling, Ronald E, Madison
*Belgea, Kathy P, Wausau
Cabatingan, Jaime D, Cedarburg
*Chang, Henry Ta-Shen, Fond du Lac
*Chelius, Carl-Juergen W H, Cudahy
*Cunningham, James A, Milwaukee
*Cushman, Stephen M, Racine
*Dasler, Herbert A, Amery
*Daugherty, Donald A, Madison
*Djokovic, Jovan L, Janesville
*Elias, Sharon L, Milwaukee
*Finucane, Patrick J, Eau Claire
*Fruchtman, Martin Z, Waukesha
*Fuh, Yen-Jen, Wauwatosa
Gapinski, Peter V, Hales Corners
*Geigler, James E, Milwaukee
Glasser, David B, Wauwatosa
Goodman, Lawrence R, Milwaukee
Gross, Jody R, Marshfield
Gross, Richard A, Milwaukee
*Guzzetta, Paul M, Milwaukee
*Han, Paul Zung-Ying, Wausau
Harris, Gerald J, Milwaukee
*Hoehne, Kurt A K, Oshkosh
*Hogan, John P, Milwaukee
*Houser, John W, Racine
*Jachowicz, Robert B, Hales Corners
*Johnson, Samuel B, Green Bay
*Kanemoto, Henry H, Wausau
*Kindschi, George W, Monroe
*Kirchner, John P, Marshfield
Klewin, Kristine M, Oconomowoc
*Knechtges, Thomas E, Elm Grove
*Knuteson, Edward L, Monroe
*Lehman, Roger H, Wood
*Lindgren, Richard D, Madison
*Martens, William E, Wauwatosa
*Mayhew, Duane G, Mequon
*Mendeloff, Gale L, Milwaukee
*Merkow, Alan J, Madison
Miller, Joel A, Madison
*Molina, Rodolfo, Beaver Dam
*Myers, Franklin L, Madison
*Nemec, George, Woodruff
*Nolan, James L, Waukesha
*Paquette, Camille A, Union Grove
*Peterson, Thomas H, Wausau
*Pinkus, Walter H, Racine
*Ravin, Erling O, Merrill
*Rawlins, Steven J, Beaver Dam
*Samadani, Ayaz M, Beaver Dam
*Schmidt, Lou R, Sparta
*Sinclair, Eugene P, Elm Grove
*Strohm, John M, Madison
Sufit, Robert L, Verona
*Tange, David B, Mosinee
*Thompson, John E, Nekoosa
*Wadina, Gerald W, West Allis
Wahlberg, Neil E, Milwaukee
*Woeste, David M, River Falls
Wolter, Robert K, Elkhorn

DECEMBER 1984

*Aaberg, Thomas M, Milwaukee
*Barthelemy, Carl R, Wood
*Basich, John E, Hales Corners
Baumann, Michael A, Brookfield
*Bedi, Ashok R, Milwaukee
*Bockelman, Henry W, Racine
*Brown, Jack D, Sparta
*Bush, Robert D, Manitowoc
Bush, Robert K, Madison
*Campbell, Richard L, Sheboygan
*Chang, Hark C, Racine
*Cline, Ross L, Monroe
*Eckstam, Eugene E, Monroe
*Effenhauser, Manfred, Lake Mills
*Erickson, Norman W, Beaver Dam
Fink, Jordan N, Milwaukee
*Frazin, Lawrence J, Milwaukee
*Gehl, Gerald A, Neenah
*Gerndt, Harold L, Manitowoc
*Gold, Kenneth I, Beloit
*Hanson, John P, Milwaukee
*Hathway, Stephen D, Green Bay
*Hermann, John P, Sheboygan
*Holzgrafe, Robert E, Waukesha
*Jacobi, Michael A, Manitowoc
*Janowak, Michael C, Oconomowoc
*Khan, Wagar A, Beaver Dam
*Khanna, Trilok S, Janesville
*Kim, Zaezeung, Milwaukee
*Markson, John W, Milwaukee
*Martin, Carroll M, Kenosha
*Mikkelson, Michael K, Merrill
*Ness, Dennis K, Mauston
*Nordholm, Vincent W, Stoughton
*Olson, Carl Erling, Mequon
Pearlman, Mary, Madison
*Peterson, Douglas B, Marshfield
*Raettig, James A, Monroe
*Rammer, Martin A, Sheboygan
Rohloff, Robert T, Milwaukee
*Sager, Mark A, Manitowoc
*Scott, Robert J, Sheboygan
*Seno, Louis S, Milwaukee
*Shaffer, Richard L, Green Bay
*Shenefelt, Philip D, Oregon
*Siegel, Lawrence K, Waukesha
*Silbar, John D, Milwaukee
*Smirl, Warren G, Waukesha
Soifer, Morton M, Milwaukee
*Stevens, Michael L, Marshfield
*Stone, Richard, Milwaukee
*Stram, Thomas W, Marshfield
Vinograd, Sherman P, Madison
*Weisenthal, Charles L, Milwaukee
*Whaley, Ralph C, Barron
*Wiviott, Wilbert, Milwaukee
*Zastrow, Raymond C, Milwaukee■

* Members of the State Medical Society of Wisconsin

Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. Dues for regular membership in 1985 are $455 for SMS, $330 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin
DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Your membership in organized medicine will help insure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Dues statements for 1985 membership in the State Medical Society of Wisconsin (county medical society membership also required; AMA membership optional but encouraged) are being mailed in November with subsequent reminder notices. For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1985 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1985 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455	$330	Normal County Dues
Resident	45.50	45	Varies
Military Service	-0-	220 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	227.50	330*	Normal County Dues
Over Age 70	227.50	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	20	Varies
Sophomore and Succeeding Medical Student Years	10	20	Varies
Postgraduate—One	10	45	Varies

*Physicians in the following categories may be eligible for exemption from paying AMA dues: (1) Financial hardship and/or disability, (2) Age 65-69 and retired from the practice of medicine, (3) Over age 70 *regardless* of retirement status.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781). ■

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Two capsules of Velosef 500 mg BID can be as effective as 250 mg QID — four capsules — of the leading oral cephalosporin... decide for yourself!

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- ☐ Five (5) First Prizes... a briefcase-size Hewlett-Packard Portable Computer valued at $3,900.00.
- ☐ 500 Second Prizes... a copy of *Computerizing Your Medical Office: A Guide for Physicians and Their Staffs* valued at $17.50

Just complete and return the attached reply card!

OFFICIAL RULES: "Computers in Health Care Drawing"
NO PURCHASE NECESSARY.
(1.) On an official entry form handprint your name, address and zip code. You may also enter by handprinting your name, address and zip code and the words "Velosef–Computers in Health Care" on a 3" x 5" piece of paper. Entry forms may not be mechanically reproduced. **(2.)** Enter as often as you wish, but each entry must be mailed separately to: "COMPUTERS IN HEALTH CARE DRAWING," P.O. Box 3036, Syosset, NY 11775. All entries must be received by September 9, 1985. **(3.) Winners will be selected in random drawings from among all entries received by the National Judging Institute, Inc., an independent judging organization whose decisions are final on all matters relating to this sweepstakes. All prizes will be awarded and winners notified by mail. Only one prize to an individual or household. Prizes are nontransferable and no substitutions or cash equivalents are allowed. Taxes, if any, are the responsibility of the individual winners. No responsibility is assumed for lost, misdirected or late mail. Winners may be asked to execute an affidavit of eligibility and release. (4.)** Sweepstakes open only to physicians residing in the U.S.A., except employees and their families of E.R. SQUIBB & SONS, INC., its affiliates, subsidiaries, advertising agencies, and Don Jagoda Associates, Inc. This offer is void wherever prohibited, and subject to all federal, state and local laws. **(5.) For a list of major prize winners, send a stamped, self-addressed envelope to: "COMPUTERS IN HEALTH CARE" WINNERS LIST, P.O. Box 3154, Syosset, NY 11775.**

VELOSEF® CAPSULES
Cephradine Capsules USP
VELOSEF® FOR ORAL SUSPENSION
Cephradine for Oral Suspension USP

DESCRIPTION: Velosef '250' Capsules and Velosef '500' Capsules (Cephradine Capsules USP) provide 250 mg and 500 mg cephradine, respectively, per capsule. Velosef '125' for Oral Suspension and Velosef '250' for Oral Suspension (Cephradine for Oral Suspension USP) after constitution provide 125 and 250 mg cephradine, respectively, per 5 ml teaspoontul.

INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis ot rheumatic fever; Veloset (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P. mirabilis, Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form ot allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth ot clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients caretully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal tunction. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility ot nephrotoxicity.

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VELOSEF® Capsules
(Cephradine Capsules USP)

BID

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

For full prescribing information, consult package insert.

HOW SUPPLIED: 250 mg and 500 mg capsules in bottles of 24 and 100 and Unimatic® unit-dose packs of 100. 125 mg and 250 mg for oral suspension in bottles of 100 ml and 200 ml.

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785-501 Issued: Jan. 1985

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BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

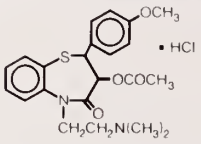
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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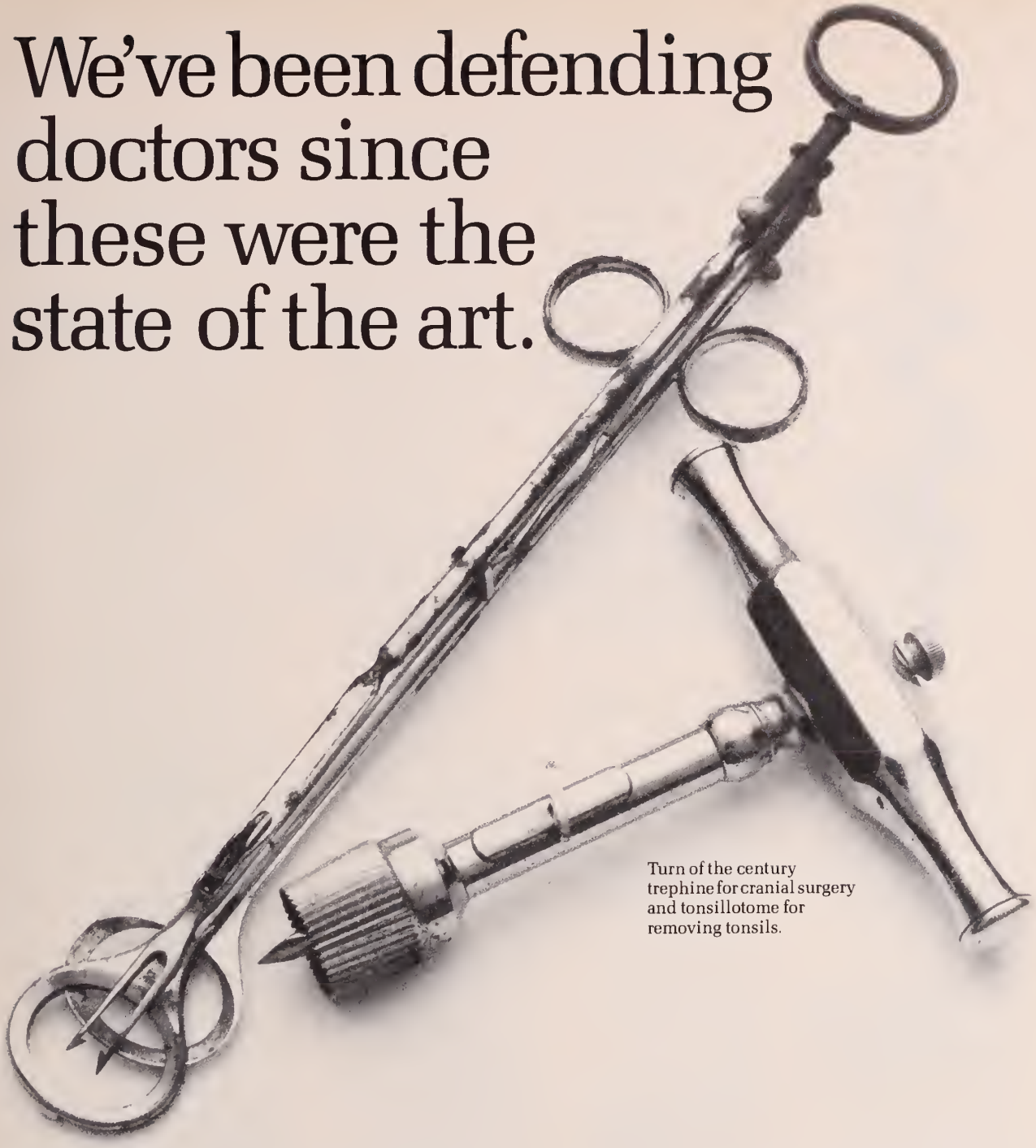

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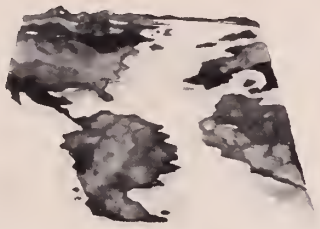
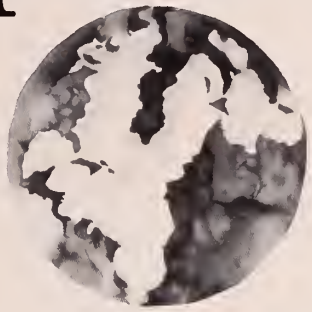
1492   1493

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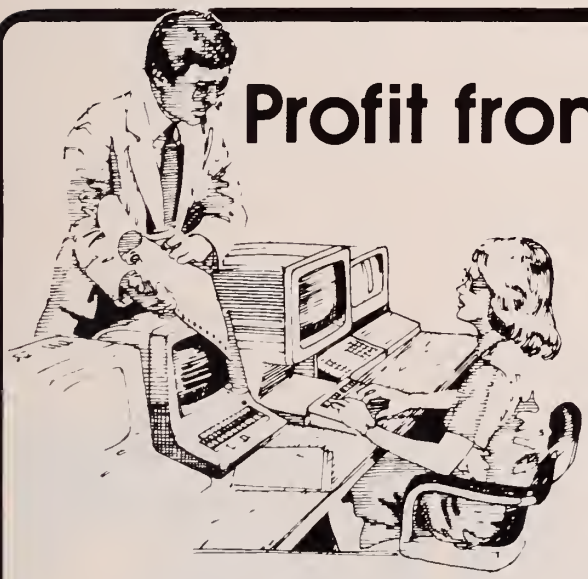

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Wisconsin and Soviet physicians meet in Chicago

When a Soviet physician takes the Hippocratic Oath, he or she recites an amended text that includes the sentence: "recognizing the threat to health and life represented by nuclear weapons, I will do all in my power to prevent nuclear war."

This is just one of the facts learned by three State Medical Society of Wisconsin physicians February 11 when they met with a group of Soviet physicians in Chicago to discuss the medical dimensions of nuclear war.

John K Scott, MD, president-elect of the State Medical Society, said the meeting "was an important first step in creating a dialogue with our Soviet counterparts so that each of us can reach out to our respective peoples and gather support for doing something about the nuclear weapons threat."

"Nuclear war is the most important medical and social issue of our time, and we as physicians have an obligation to do something to prevent it," he said. "A physician becomes obsolete in nuclear war."

Other Madison physicians who met privately with the Soviet delegation were Jack S Westman, MD and Marc Hansen, MD, the latter being a member of the Society's Ad Hoc Committee on the Public Health Consequences of Nuclear War. Doctor Westman is the author of a 1982 Society resolution which says the Society "encourages efforts to provide reliable scientific information to the profession and the public regarding the medical consequences of nuclear weapon explosions, and requests our public and professional representatives at the state, national, and international levels to take whatever carefully considered steps are necessary to reduce the likelihood of nuclear weapon explosions." According to Bernard Lown, MD, copresident of the International Physicians for Prevention of Nuclear War (IPPNW), the State Medical Society of Wisconsin was the first medical society in the nation to take such an action.

The meeting in Chicago was the first stop for the Soviet physicians in a five-city US tour organized by IPPNW. Soviet physicians present were Evgueni I Chazov, MD, director general of the National Cardiological Research Center for the USSR, and copresident of the IPPNW; Mikhail Kuzin, director of the Vishenevsky Surgical Institute, and Nikolai Trapeznikov, deputy director of the USSR Oncology Research Center. Other American physicians present were Sidney Alexander, MD, president of Physicians for Social Responsibility, and Bernard Lown, MD, copresident of the IPPNW.

During the meeting, the Wisconsin physicians invited their Soviet colleagues to visit Madison during a US tour planned for next fall. The visit would include a meeting with local physicians to exchange scientific information as well as to discuss what can be done to prevent nuclear war.

Before ending the meeting the physicians shared photographs of their grandchildren with each other. "Afterall," said Doctor Scott, "it's because of them that we're doing this."

—Prepared by *Diane Upton*
SMS Communications Coordinator ■

Left to right: Jack S Westman, MD, Madison; John K Scott, MD, Madison; Mikhail Kuzin, MD, director of the Vishenevsky Surgical Institute, USSR; Marc Hansen, MD, Madison; Nikolai Trapeznikov, MD, deputy director of the USSR Oncology Research Center; Bernard Lown, MD, Boston, Mass, copresident of International Physicians for the Prevention of Nuclear War (IPPNW); and Evgueni I Chazov, MD, director general of the National Cardiological Research Center, USSR, and copresident of IPPNW. (Staff photos by Diane Upton)

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SMS speaks out on mandated benefits, involuntary commitment laws

Mandated benefits for alcoholism, drug abuse, and mental health services along with involuntary commitment proceedings were discussed at legislative committee meetings at which SMS spokespersons testified in March.

The 1985–87 biennial budget includes an amendment to state laws pertaining to mandated insurance benefits. Under the proposal, required inpatient coverage would be reduced from 30 days to the lesser of $6,300 or 25 days, with a 10 percent copayment by the recipient. Outpatient coverage requirements would be increased from $500 to $1,000, with a 10 percent copayment; also a requirement is added for $1,000 worth of coverage for day treatment/partial hospitalization, with a 10 percent copayment. Total annual coverage (inpatient, outpatient, and day treatment) would not have to exceed $7,000.

At a hearing held by the Joint Finance Committee March 5, SMS objected to these proposed changes and called for repeal of the current mandated benefits. SMS charged that the effect of state mandates in this area has been to increase the cost of health insurance, to reduce the purchasers' and consumers' ability to choose policies which reflect their needs, and to increase the incentive to move to self-insurance, which is not subject to these mandates.

"The State Medical Society opposes discrimination against particular disease entities in insurance policies; but mandated benefits have not proved to be an effective or appropriate route to preventing such discrimination or encouraging the provision of coverage for cost-effective care," SMS said.

The next day on March 6, SMS testified in support of a bill which is designed to improve the handling of involuntary commitment proceedings. The bill would provide that both sides in a proceeding notify the other of proposed witnesses; would allow petitions at the probable-cause stage to be more easily switched between alcoholism grounds and drug dependence or mental illness grounds; and would allow the use of outpatient treatment records, as well as inpatient treatment records, in determining dangerousness when a person has received such treatment under a court-ordered commitment. The bill would also allow proceedings for involuntary commitment, when a person agrees to voluntary treatment, to be held open for 30 days rather than 14 days; and provides that when a person is taken into custody pending involuntary commitment, a preliminary hearing must be held within 72 hours of the time they are taken into custody, rather than 48 hours after receipt of a petition.

SMS pointed out to the committee that these changes address oversights in the current law as technical problems which should be rectified. "However," SMS stressed, "we should not assume that passage of this bill will solve all of the problems that exist with the current mental commitment laws . . . the adoption of an additional commitment standard is necessary now which would allow treatment of persons who will suffer substantial mental deterioration of informed consent or refusal of treatment." ■

SMS testifies on peer review legislation

A bill which would require all malpractice claims to be referred to the State Medical Examining Board would put an unrealistic caseload on the Board, Gerald Kempthorne, MD, told a Senate Committee March 12.

Speaking on behalf of the State Medical Society and its Commission on Mediation and Peer Review, Doctor Kempthorne said that SMS strongly agrees with the intent of Senate Bill 75 that there must be a mechanism for peer review of cases involving negligence on the part of the physicians whether the case is settled, or tried to verdict.

"However, it must be understood," Doctor Kempthorne said, "that physicians have no voice in settlement decisions, and therefore it is inappropriate to initiate an investigation of unprofessional conduct based solely on an insurance company's economically-motivated settlement practices."

SMS proposes referral of all negligence findings, all claims settled (without a negligence finding) for more than $25,000, and all claims settled which involve the death of a patient. SMS has also offered to serve as a resource to the MEB for screening panel cases and making recommendations regarding prioritization of these new referrals. This recommendation has been adopted by the Legislative Council's Special Committee on Medical Malpractice as part of a comprehensive package to deal with the medical liability situation in Wisconsin.

SB 75 has been recommended for passage by the Senate Agriculture, Health and Human Services Committee and is now in the Joint Finance Committee. ■

Malpractice premiums to rise 106%

The Board of Governors of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) and Patients Compensation Fund voted on February 25 to increase medical malpractice insurance rates as of July 1, 1985:

69% for WHCLIP, and
160% for the Fund

The combined effect of these increases is an overall rate increase of approximately 106 percent. Below is a chart comparing current rates to the proposed July 1, 1985 rates.

Class	*Total (WHCLIP & Fund) Premium*	
	1984	*1985*
1	2,323	4,806
2	4,646	9,613
3	5,976	12,363
4	7,170	14,834
5	11,950	24,724
6	14,340	29,668
7	16,730	34,613
8	1,162	2,404
9	25,096	51,921

In order to determine the impact of these rate increases on the availability and cost of healthcare, all SMS members are being asked to respond to a one-page, mini-survey. The survey seeks physician views on the impact of the medical liability climate on practice patterns and charges to patients and on prioritization of reforms needed in Wisconsin. The results will be communicated to the Legislature. Prompt attention to this matter is critical. ■

SMS asks business leaders' help on malpractice problem

SMS President Timothy Flaherty, MD has called upon the business community to assist physicians in resolving the medical malpractice problem in the state. In a letter to the chief executive officers of the 500 largest corporations in the state, Doctor Flaherty said that professional liability constituted a major and unnecessary component in healthcare costs, and that employers pay the bill for these costs through employee health insurance premiums. Included with the letter was a copy of an UPDATE on "Medical Liability in Wisconsin: Problems and Recommendations for Change." The report, which has been sent to legislators and all Wisconsin physicians, outlines the crisis on medical malpractice and the Society's recommendations for action. Doctor Flaherty asked the executives to make their opinions on the subject known to their legislators, as the "Legislature holds the key to some short-term solutions to this problem." ■

Joint Finance Committee considers healthcare regs

The Joint Finance Committee's health discussion group is taking up the question of changes in Wisconsin's healthcare regulations, specifically the repeal or modification of the Capital Expenditure Review (CER) program and the Hospital Rate-Setting Commission. The State Medical Society, along with such legislators as Senators John Norquist (D-Milwaukee), advocated for a competitive approach toward controlling healthcare costs. One of the most important steps in moving from a regulatory to a competitive environment is the elimination of the Capital Expenditure Review. Under this program, state approval is needed for capital expenditures over $600,000, including purchases of clinical equipment for physicians' offices and for a change in a hospital's service which increases revenue by more than $200,000. State approval is also needed for such things as ambulatory surgery centers and home health agencies. An increasing number of legislators are considering elimination or reduction of the CER program and the Hospital Rate-Setting Commission. This will be voted on within the next couple of weeks by the health discussion group (co-chaired by Senator John Norquist) of the Joint Finance Committee. However, the Governor and the Department of Health and Social Services are lobbying to save their regulatory clout. They claim that the CER program and the Hospital Rate-Setting Commission have worked to control healthcare costs, and that we should not "tamper" with them. ■

Malpractice seminar scheduled for May 11

"Malpractice: Can the Picture Be Changed" is the subject for a two-day conference the State Medical Society is sponsoring for physicians at the Hyatt Regency Hotel, Milwaukee, May 10 and 11.

A project of the Society's Medical Liability Committee, the conference will focus on how malpractice incidents can be reduced as well as what medical-legal steps can be taken to improve the medical liability situation.

Topics will include: "Malpractice: What It Is, How It Happens"; "What Is Malpractice"; "What Gets Physicians Into Malpractice Trouble"; and "How to Minimize Your Risk of a Lawsuit."

Registration is $70 for SMS members and $150 for nonmembers. For further information to register, contact Deborah Powers at the SMS Physicians Alliance Division in Madison. ■

wispac

William L Treacy, MD; Chairman
WISPAC Board of Directors

A brief profile of the 1985 Wisconsin State Legislature

- The new State Assembly will feature more Republicans than any session since 1969, the last year they held the majority. Increasing their ranks in the Assembly from 40 to 47 in the fall elections, Republicans will still be the minority party with Democrats controlling both houses—52 to 47 in the Assembly and 19 to 14 in the Senate.

- This year there are 25 women in the Legislature—3 senators and 22 representatives—which equals the record high. In the early 1970s there were as few as four women legislators, all in the Assembly.

- There are five new members in the Senate and 24 first-term Assembly members. Fred Risser, a Madison Democrat, has seniority in the Senate. He was elected in 1962 after serving six years in the Assembly.

  Earl McEssy, a Fond du Lac Republican, is dean of the Assembly. He has been reelected 14 times since first becoming a member of the Legislature in 1956.

- The average age of state senators is 42.8, compared with 41.6 in the Assembly. The range is 24 to 72 years of age.

- Law and farming are predominant current occupations in the Legislature—with 23 attorneys and 18 farmers. Nineteen legislators list teaching as a former career. Other Senate occupations range from retired naval officer and telephone cable splicer to such businesses as electrical contracting, metal recycling, property management, and communications consulting. In the Assembly, employment has included such activities as investment broker, insurance agent, public relations consultant, part-time sports announcer, feed dealer, land surveyor, pharmaceutical consultant, and community volunteer.

  Eight senators and 19 representatives list previous employment in a legislative staff position.

- Twenty-six senators and 73 representatives, or 75 percent of the Legislature, have graduated from college. The breakdown includes 23 law degrees, 1 PhD degree, and 18 Master's degrees.

- Legislators elected in 1984 will draw $27,202 a year in salary. Holdover senators will still receive $22,632. Besides their salaries, legislators outside Dane County may receive up to $41.63 a day in living expenses while they are in Madison on state business. Members of the Dane County delegation are allowed up to $20.81 in expenses.■

The WISPAC-sponsored socioeconomic luncheon at the SMS Annual Meeting in La Crosse is scheduled for Friday, April 26, from 11:45 am to 1:30 pm

This year, the guest speaker will be Mark Shields, a political columnist for the *Washington Post.* He also has done special election coverage for NBC and CBS, and for sometime he hosted "Inside Washington," a PBS weekly television show.

The luncheon is open to everyone, however, tickets should be ordered as soon as possible.

*Statistics provided by the Wisconsin Legislative Reference Bureau.

Herman P Musch, MD, Baraboo, recently began his medical practice in Baraboo. Doctor Musch graduated from Mayo University of San Simon in Bolivia, South America. He spent two years practicing in a rural area in South America as a government-appointed physician. For three years Doctor Musch directed a research program on nutrition for the Patino Foundation of Bolivia. He completed his internship at Mercy and Raymond Blank Memorial Hospital for Children in Des Moines.

Joseph E Powell, MD,* New Richmond, is among eight rural Wisconsin, Minnesota, and North Dakota physicians selected for a Bush Clinical Fellowship Award. Doctor Powell, a family practitioner at Holy Family Hospital and at New Richmond Clinic, will spend nine months during a three-year period using the award for advanced study in critical care medicine and geriatrics. The "Clinical Fellow" awards, made by the Bush Foundation of St Paul, allow the selected rural physician to spend from three months to a year learning new clinical and leadership skills. Doctor Powell has been in medical practice in New Richmond for the past 13 years.

George R Thuerer, MD,* Rhinelander, after 36 years of medical service in the community, retired in December 1984. Doctor Thuerer came to Rhinelander in 1949 after completing four years of surgical residency at University of Wisconsin Hospital in Madison. He had been in the United States Army Medical Corps for 54 months during World War II, including 39 months in the South Pacific Theater. Doctor Thuerer has served as an associate preceptor for the University of Wisconsin-Madison Medical School and is a fellow of the American College of Surgeons.

Melvin F Huth, MD,* Baraboo, received the Wisconsin Athletic Director Association's Distinguished Service Award during ceremonies held at the Marc Plaza Hotel in Milwaukee. The awards are presented annually as an expression of appreciation for years of distinguished service to high school athletics. In presenting the award, Bob Roloff, Baraboo High School Athletic Director, said, "Doctor Huth has touched many people in Baraboo. He plays a vital and active role in the athletic program and serves as physician in attendance at nearly all home games. He has a personal appreciation of continuing education and believes that participation in athletics teaches effort, and that effort is the forerunner of success in all later life endeavors." Doctor Huth has donated his services to high school athletes by providing WIAA physical examinations and other services to local athletic programs for some 38 years.

Moe L Chin, MD,* Watertown, has become medical director of the Beverly Terrace Nursing Home in Watertown. Doctor Chin graduated from the University of Washington School of Medicine and completed his family practice residency at St Michael's Hospital in Milwaukee. Board certified, Doctor Chin has been in private practice in Watertown since 1980.

Joyce A Yerex, MD,* Kenosha, has been elected president of the Kenosha Memorial Hospital medical staff for 1985. Doctor Yerex, a radiologist on the medical staff since 1977, graduated from the University of St Andrews in Scotland and served residencies at Milwaukee County and Columbia hospitals in Milwaukee.

Susan F Behrens, MD,* Beloit, has been elected to fellowship in the American College of Surgeons. Doctor Behrens is on the medical staff of the Beloit Clinic and is chairman of the Wisconsin Medical Examining Board. She also is a member of the Long Range Planning Committee for the National Federation of State Medical Boards and has been asked to serve on a Task Force for the National Board of Medical Examiners to rewrite Part III of the examination.

Kathryn A Green, MD, Sheboygan, has opened her medical practice in ophthalmology in Sheboygan. Doctor Green graduated from the Indiana University School of Medicine and served her internship in Portland, Ore. Her residency training was completed at the Eye Institute at Milwaukee County Medical Complex. Doctor Green is on the medical staff at St Nicholas and Sheboygan Memorial hospitals.

William Odette, MD, Edgerton, recently became associated with the medical staff of the Edgerton Clinic. Doctor Odette graduated from Wayne State University School of Medicine, Detroit, and completed his residency at the Southwestern Michigan Health Education Center in Kalamazoo, Mich.

David G Crawford, MD,* (above), Madison, has been appointed instructor of psychiatry at the University of Wisconsin Medical School. He joins the staff of UW Hospital and Clinics' Center for Affective Disorders and director of the inpatient unit. Doctor Crawford graduated from the University of Oklahoma School of Medicine and completed his residency at the University of Wisconsin, Madison.

Doctor Watts

Doctor Crawford

Doctor Cohen

Doctor Soderquist

David Cohen, MD (above), Madison, recently was appointed assistant professor of surgery at the University of Wisconsin Medical School. Doctor Cohen graduated from Washington University School of Medicine, St Louis, Mo, and completed his residency at Johns Hopkins Hospital and the University of Washington Affiliated Hospitals. He also completed a residency in cardiothoracic surgery at the University of Pennsylvania. Doctor Cohen previously held positions in the department of cardiovascular physiology at Walter Reed Army Institute of Research and in cardiothoracic surgery at Brooke Army Medical Center.

David T Watts, MD (above), Madison, recently was appointed assistant professor of medicine at the University of Wisconsin Medical School. He joined the medical staff of the UW Hospital's geriatric clinic and the UW Hospital Middleton Clinic. Doctor Watts graduated from the University of Washington School of Medicine and served a fellowship at the VA Medical Center, Portland, Ore.

Catherine Soderquist, MD (above), recently joined the medical staff of the DeForest Area Medical Clinic. Doctor Soderquist graduated from the University of Minnesota School of Medicine and completed her family practice residency at the University of Wisconsin Medical School, Madison. She was in private practice in Eagan, Minn, a suburb of Minneapolis, until joining the DeForest Clinic.

Joseph H Evans, MD, Marshfield, has joined the medical staff of the Marshfield Clinic. Doctor Evans graduated from Jefferson Medical College in Philadelphia and served his internship and completed his residency at the University of Wisconsin Hospital and Clinics in Madison. He also completed a fellowship at Indiana University Hospital in Indianapolis.

Paul Groben, MD, Platteville, recently joined the medical staff at the Southwest Health Center. Doctor Groben graduated from the University of Iowa School of Medicine and completed his rotating internship at Doctors' Hospital in Columbus, Ohio. His residency in radiology was completed at Grandview Hospital in Dayton, Ohio. Doctor Groben has practices in Platteville and Cuba City and is a faculty member at the University of Wisconsin in Madison.

Bruce E Brink, MD, Marshfield, has joined the medical staff of the Marshfield Clinic. Doctor Brink graduated from the University of Michigan Medical School, Ann Arbor, and completed his internship and residency at University Hospital in Ann Arbor. Prior to joining the Clinic, Doctor Brink was an associate professor and vice chairman of the Department of Surgery at the University of Texas Southwestern Medical School in Dallas.

Terrance J Wilkins, MD,* who currently has offices in Milwaukee and Mequon, has established an office at the Marsho Medical Clinic in Sheboygan. Doctor Wilkins graduated from the Medical College of Wisconsin and completed his internship at St Joseph Hospital in Denver. His residency training was completed at St Joseph's and the Medical College of Wisconsin Hospitals in Milwaukee. He also completed training at Indiana University Hospital in Indianapolis.

Kathleen Farah, MD, who is completing her residency at St Paul Ramsey Medical Center in St Paul, Minn, is joining the medical staff of the Curtis Medical Clinic, Baldwin, this summer. Doctor Farah graduated from the University of Minnesota Medical School.

Kita Patel, MD, recently joined the medical staff of the Hartford Memorial Hospital. Doctor Patel served her internship at St Francis Hospital, Pittsburgh, Pa, and her residency in anesthesiology at the Medical College of Wisconsin, Milwaukee. Doctor Patel has served as acting director of anesthesiology at Mount Sinai Medical Center and has also served as assistant professor of anesthesiology at the Medical College of Wisconsin.

John D Silbar, MD,* Milwaukee, was elected president of the North Central Section of the American Urological Association at its Annual Meeting. The North Central Section is one of the largest sections of the American Urological Association and consists of 1200 practicing urologists in the North Central United States and parts of Canada. Doctor Silbar is a clinical professor at the Medical College of Wisconsin and is on the medical staff of the Clinic of Urology, SC, in Milwaukee.

Robert Braastad, MD, Eau Claire, has joined the medical staff at Sacred Heart Hospital in Eau Claire. Doctor Braastad graduated from the Emory University School of Medicine, Atlanta, Ga, and completed a three-year residency at the Gundersen Clinic and Lutheran Hospital, La Crosse. He is associated with Group Health Cooperative in Eau Claire and for the past two years he was at the Alexandria Clinic in Alexandria, Minn.

J Gregory Hoffmann, MD, recently became associated with the medical staff at Hartford Memorial Hospital. Doctor Hoffman served a family practice residency at St Mary of Nazareth Hospital in Chicago, and also at the University of Health Science of the Chicago Medical School. He is affiliated with the Hartford-Parkview Clinic.

Francis Wolf, MD, has become a member of the medical staff at Hartford Memorial Hospital. Doctor Wolf served his internship at Roger Williams Hospital of Brown University in Providence, RI and his residency and fellowship were completed at Mount Sinai Medical Center in Milwaukee. Doctor Wolf is affiliated with the Hartford-Parkview Clinic.

Randall W Lewis, DO,* Menominee, has been named medical director at Woodland Village Nursing Home in Suring. Doctor Lewis graduated from the University of Health Sciences in Kansas City, Mo, and served a rotating internship at Lakeview Hospital in Milwaukee. He was associated with the Pound Community Clinic before opening his own practice in Crivitz. He is on the medical staff of Marinette General Hospital and Menominee County Lloyd Hospital.

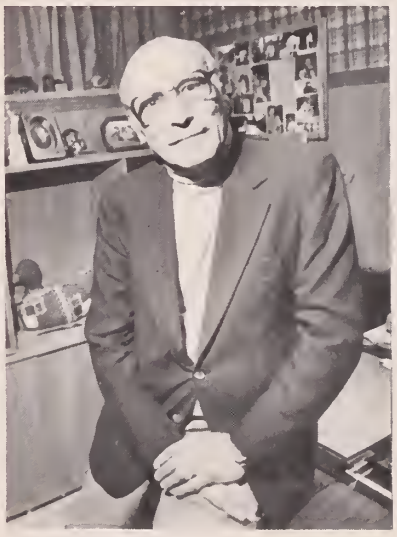
Joseph J Grimm, MD,* Milwaukee, retired from his medical practice after 50 years of practice. Doctor Grimm was a barber before graduating from Loyola Medical School in Chicago in 1928. He served an internship at St Mary's Hospital in Milwaukee and later did postgraduate studies in Austria for training as an eye, ear, nose, and throat specialist.

James Byrd, MD, Wauwatosa, recently was appointed assistant professor of medicine at the Medical College of Wisconsin in Milwaukee. Doctor Byrd graduated from the University of Minnesota Medical School in 1978. He completed a fellowship at the Boston University School of Medicine and also received a master's degree from the Boston University School of Public Health.

William J Maurer, MD,* Marshfield, was reelected president of the Marshfield Clinic medical staff. Cesar N Reyes, MD,* was reelected as vice president, John P Milbauer, MD,* was named secretary, and Richard H Ulmer, MD* is treasurer. Doctor Maurer, a graduate from the Marquette University Medical School, will be serving his third successive term. He has been a member of the Clinic medical staff since 1968.

James Williams, MD, Onalaska, recently was certified as a diplomate of the American Board of Emergency Medicine. Doctor Williams is a graduate from the University of Iowa College of Medicine, Iowa City. A member of the Gundersen Clinic and La Crosse Lutheran Hospital medical staff, Doctor Williams is chairman of the Department of Trauma and Emergency Medicine.

George V Murphy, MD,* South Milwaukee, recently was honored for his 17 years of service as medical director of Franciscan Villa Nursing Home. He served as medical director from 1967-1984. Antonio A Malapira, MD is the new medical director.



Doctor Schroeder

Jack D Schroeder, MD,* (above) Janesville, recently retired from his medical practice of 38 years. Doctor Schroeder graduated from the University of Wisconsin Medical School after serving in the United States Army Air Corps during World War II. He was on the medical staff of the Janesville Medical Center of which he was a founding member in 1958. (Photo courtesy of *Janesville Gazette*)

Milwaukee Psychiatric Hospital, Wauwatosa, recently announced the opening of the McBride Center for the Impaired Professional. The Center will provide a full-range of inpatient and outpatient services for physicians, nurses, pharmacists, business executives, dentists, lawyers, and other professionals who are experiencing substance abuse disorders, according to Center director, Roland E Herrington, MD.* A full multidisciplinary staff, including physicians, nurses, counselors, clergy, and activity therapists is involved in the conduct of the program. Arthur G Morris, MD is medical director of psychiatric services for Milwaukee Psychiatric Hospital and the McBride Center. He is joined in this special effort at the McBride Center by three other specialists in addictive disease medicine, Richard L Hauser, MD,* David Benzer, DO, and Charles H Engel, MD.* Nancy Cervenansky, RN coordinates the treatment program for nurses.

Sauk-Prairie Memorial Hospital medical staff has elected new officers for 1985. They are MDs Arnold N Rosenthal,* president; Ihor A Galarnyk,* vice-president, and Matthew Grade, secretary-treasurer.

Holy Cross Hospital medical staff, Merrill, has elected Jerome S Mayersak, MD* as president of the medical staff for 1985. Doctor Mayersak has practiced in the Merrill area since 1971. Other 1985 Holy Cross Hospital medical staff officers include MDs Donald L Evans,* vice president, and Jack D Millenbah,* secretary-treasurer, all from Merrill.

UW Hospital and Clinics, Madison, medical staff has elected staff officers and at-large members of the medical board for 1985 and 1986. They are MDs Dolores A Buchler,* president, OB/GYN; Thomas A Duff,* vice president, surgery/neurosurgery; Louis Chosy, secretary-treasurer, medicine. At-large members are MDs Carolyn Bell, medicine; Andrew B Crummy,* radiology; Thomas Davis, oncology; Jonathan Finlay, pediatrics; Norman M Jensen,* medicine; Eberhard Mack, surgery; Guillermo Ramirez, oncology; and Sander S Shapiro,* OB/GYN.

The American Cancer Society/ Wisconsin Division has awarded $75,000 professorship of clinical oncology to the University of Wisconsin Medical School. Ernest C Borden, MD, professor of human oncology and medicine, received the three-year grant, which is aimed at strengthening collaborative efforts in cancer control between ACS and the UW Medical School. Doctor Borden has been medical director-at-large on the ACS/Wisconsin Division board of directors since 1979.

Sheboygan Memorial Hospital recently announced the election of Paschal A Sciarra, MD* as president of the medical staff for 1985. Wendelin W Schaefer, MD* was elected vice president and Jonathan V Moulton, MD* was elected secretary-treasurer. Doctor Sciarra has practiced medicine in Sheboygan since 1958 and succeeds Martin A Rammer, MD.* Doctor Sciarra is a member and past president of the Wisconsin Otolaryngological Society and member of the Milwaukee Society of Otolaryngology-Head and Neck Surgery. He is currently an associate clinical professor at the Medical College of Wisconsin, Milwaukee, a position he has held since 1959.

De Paul Rehabilitation Hospital, Milwaukee, has maintained an Impaired Physician Program since 1977. It has been expanded to include other professionals, including dentists, nurses, lawyers, pharmacists, and business executives. The Hospital's Impaired Professional Program is under the direction of William McDaniel, MD as medical director. Mark D Biehl, MD* and August D Kropp, MD* are co-medical directors. Director of the Impaired Professional Program is Carrie Weddle, RN, BSN with Brinda Adams, RN as nurse manager of the Impaired Nurse Program. Staff physician is James Zarzynski, MD.

Elmbrook Memorial Hospital, Brookfield, has announced the appointment of two new department chairmen. Lawrence L Foster, MD,* Brookfield is chairman of the Department of Orthopaedic Surgery and Peter T Hansen, MD,* Brookfield is chairman of the Department of In-Hospital Service. Other physicians to continue as department chairmen are John P Walsh, MD,* Surgery; Michael F Banasiak, MD,* Medicine; Herbert C White, DO,* Family Practice; and James A Stadler, MD,* Obstetric/Gynecology; John J Vondrell, MD,* chief-of-staff; Robert S Pavlic, MD,* chief-of-staff-elect, and Robert O Buss, MD,* secretary-treasurer. ■

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*Registered trademark of Ciba-Geigy Corp for tripelennamine.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

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TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions Usage with Alcohol* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C* Should be given to pregnant women only if clearly needed. *Labor and Delivery* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers* Caution should be exercised when administered to a nursing woman. *Pediatric Use* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope. *Respiratory* Rarely, respiratory depression. *CNS Acute CNS Manifestations* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic* Visual blurring and focusing difficulty. *Hematologic* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

Please consult full product information before prescribing.

Winthrop-Breon

WIN 4-41415FR

Winthrop-Breon Laboratories
Division of Sterling Drug Inc
New York, NY 10016

PUBLICATION INFORMATION

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about four months following acceptance, and in the order in which they are received.

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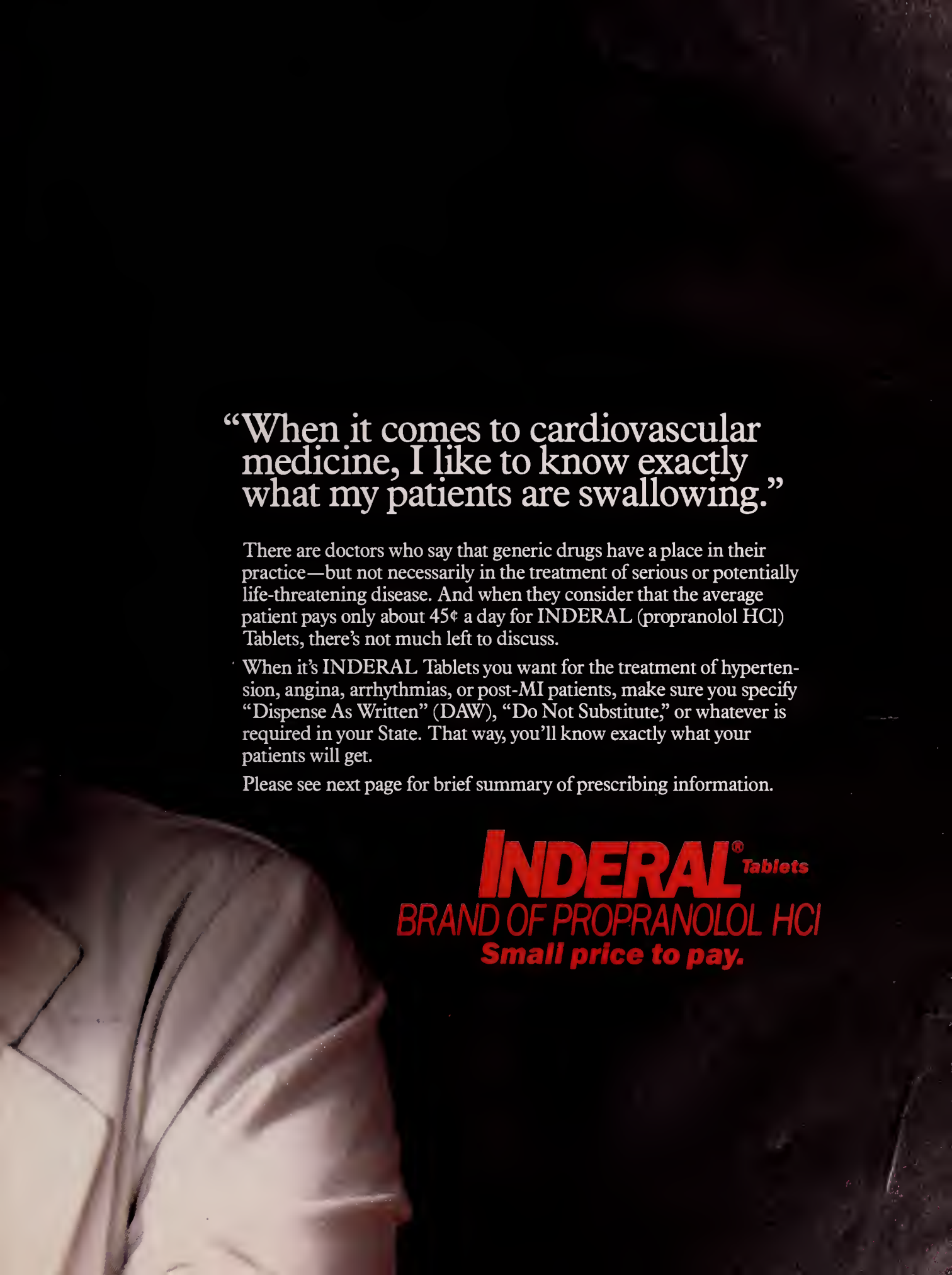
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR)

INDERAL® (propranolol hydrochloride) Tablets

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS

CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure the patient should be digitalized and/or treated with diuretics, and the response observed closely or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g , dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS

General Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL (propranolol hydrochloride) may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type

Central Nervous System Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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but angina still
strikes...

After a nitrate, add ISOPTIN®
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To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C.* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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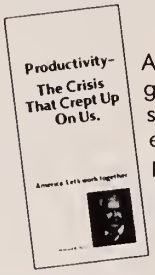

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William N Young, MD, 60, Milwaukee, died Dec 18, 1984 in Milwaukee. Born Dec 1, 1924 in Chelsea, Mass, Doctor Young graduated from Tufts University Medical School, Boston, Mass, and completed his internship at Great Lakes Naval Hospital, Great Lakes, Ill. His residency was completed at Affiliated Hospitals in Massachusetts. He retired from medical practice in 1984. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Richard E Jensen, MD, 61, Green Bay, died Nov 29, 1984 in Green Bay. Born Oct 11, 1923 in Duluth, Minn, Doctor Jensen graduated from the University of Minnesota School of Medicine and served his internship at St Mary's Hospital in Duluth, Minn. He served in the United States Navy during World War II and the Korean War. Doctor Jensen had practiced medicine in Green Bay since 1951. He was a member of the medical staff of St Mary's, St Vincent, and Bellin hospitals, and had served as president of St Mary's and had served as chief of the Department of Family Medicine at St Vincent Hospital. Doctor Jensen was a member of the Brown County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Molly, and ten children; Mrs Terry (Kathleen) Kuehne, Seymour; Mrs Ben (Rose) Kreilkamp, Minneapolis, Minn; Dr Richard Jensen Jr, DePere; Mrs Dennis (Martha) Duffy, Green Bay; Christopher and Paul, Green Bay; Elizabeth, Austin, Tex; Suzanne, Sarah, and Michael, all at home.

Albert P Hable, MD, 76, Marshfield, died Dec 30, 1984 in Marshfield. Born Jan 2, 1908 in Bloomer, Doctor Hable graduated from Marquette University School of Medicine in 1931 and served his internship at Milwaukee County General Hospital. Doctor Hable practiced medicine in Loyal for over 42 years. He was a member of the Clark County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, one son, Paul, Ft Atkinson; four daughters, Mrs Luke (Mary) Eiche, Slinger; Mrs Oliver (Dr Kathleen) Rhodes, Rochester, Minn; Mrs James (Dr Jane) Etner, Binghamton, New York, and Miss Ann Hable of Milwaukee.

Donald F Jarvis, MD, 68, Tomahawk, died Jan 23, 1985 in Tomahawk. Born Jan 28, 1916 in Tomahawk, Doctor Jarvis graduated from Marquette University School of Medicine in 1944 and completed his internship at Milwaukee County General Hospital. Doctor Jarvis began his medical practice in Tomahawk in 1950 and retired in 1983. He served as city health officer from 1968-1983. He had been a member of the medical staff of Sacred Heart Hospital and also a member of the board of directors. Surviving are his widow, Ruth; three sons, Charles, Tomahawk; Donald, Deerfield; James, Rhinelander; and four daughters, Heidi, Tomahawk; Janis, Wausau; Mrs Jeffrey (Jean) Dean, Marshfield; and Holly of Seattle.

Nicholas D Demeter, MD, 89, Wauwatosa, died Jan 25, 1985 in Wauwatosa. Born Dec 15, 1895 in Vissani, Greece, Doctor Demeter graduated from the University of Illinois Medical School and completed his internship at St Joseph Hospital in Marshfield. He served in the United States Army during World War I and World War II. He received the Certificate of Merit in 1950 for his wartime service with the Selective Service System. He served as a trustee for the Milwaukee Public Museum from 1941 to 1949 and with the Milwaukee Public Library from 1949 to 1962. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Dena; one son, James, Chicago; three daughters, Mary Thurrell, Madison; Constance Caranasos, Gainesville, Fla; and Lela, a medical student in Greece.

Russell C Darby, MD, 75, Oshkosh, died Jan 27, 1985 in Neenah. Born June 14, 1909, Doctor Darby graduated from Loma Linda Medical School, California, and served his internship at St Agnes Hospital in Fond du Lac. Doctor Darby completed his residency at Good Samaritan Hospital, Phoenix, Ariz. He had practiced in Wautoma for a number of years and retired in 1982. Doctor Darby served in the United States Army Medical Corps from 1942-1946. Surviving are his widow, Gladys; one daughter, Nadine Hanneman, Appleton; and one son, Roderick of Oak Brook, Ill.

William H Studley, MD, 81, Shorewood, died Feb 3, 1985 in Shorewood. Born Feb 7, 1903 in Milwaukee, Doctor Studley graduated from Columbia University Medical School in 1929 and served his internship at St Mary's

Hospital in Milwaukee. He joined the medical staff of the Shorewood Hospital and in 1934 became medical director of the facility. The hospital was sold to Columbia Hospital in 1969 and Doctor Studley remained the director until 1978 when he retired. He was on the board of the State Public Welfare Department from 1949 until it became part of the Department of Health and Social Services in 1967. He then became the first board chairman and served for five years. Doctor Studley was awarded an honorary membership in 1971 by the International Institute for his help in supporting a family of Vietnamese immigrants. He was an associate in Neurology on the Marquette University School of Medicine (now the Medical College of Wisconsin) faculty from 1937 to 1959 and associate clinical professor from 1959 until retirement. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Frieda; a daughter, Elizabeth Carlson, Boulder, CO, and a son, William F of Los Angeles, CA.

[A close friend and colleague of Doctor Studley, Dr George Moore of Ashland, Illinois, gave the eulogy which was published in the March issue of the Journal.]

Paul B Mason, MD, 78, a Sheboygan physician for 41 years, died Feb 8, 1985 in Sheboygan. Born Jan 14, 1907 in Chippewa Falls, Doctor Mason graduated from Northwestern University School of Medicine and completed his internship at Passavant Hospital, Chicago. His residency was served at the Mayo Clinic in Rochester, Minn. Doctor Mason had been associated with the Sheboygan Clinic from 1936 until his retirement in 1977. He was president of the Sheboygan Clinic Association from 1955-1972. Doctor Mason was a member of the medical staff at St Nicholas and Memorial hospitals and served as president of St Nicholas from 1973-74. At the 25th Annual Meeting of the Wisconsin Heart Association in 1971, Doctor Mason was presented with the association's medallion in recognition of his contribution to the association's founding. In 1973 he was the recipient of the University of Wisconsin Medical School's Max Fox Preceptor Award and in 1978 Doctor Mason was given the Civic Leadership award of the State Medical Society in recognition of his outstanding dedication to the progress of medicine and involvement in the democratic process. The Wisconsin Professional Review Organization recognized him in 1980 for "his rare foresight and restraint in directing the development of a more sophisticated peer review methodology" through the Peer Review Committee of the State Medical Society for his encouragement and aid in the development of WisPRO as the first president of Wisconsin Health Care Review Inc. In 1982 he became a member of the "50 Year Club" of the State Medical Society. He was a member and served as president of the Sheboygan County Medical Society and also was a member of the American Medical Association. He was a member of the American College of Physicians and the American College of Cardiology. Surviving are his widow, Mollie; a daughter, Mary Lou Smith, and a son, Paul B Mason, Jr.

Philip W Limberg, MD, 67, Glenwood City, died Feb 9, 1985 in Eau Claire. Born Oct 21, 1917 in Greenbush, Doctor Limberg graduated from the University of Wisconsin Medical School, Madison, in 1942. His internship was served at Christ Hospital, Cincinnati, Ohio, and his surgical residency was completed at Deaconess Hospital, Milwaukee. He served in the United States Army Medical Corps from 1943-45 during World War II. In 1946 he moved to Glenwood City to begin his medical practice. For the past three and a half years, Doctor Limberg had served as a physician at UW Stout Student Health Service. He was a member of the Pierce-St Croix County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Roberta, one son, Philip, Lake Tomahawk; and three daughters, Mrs Howard (Gail) Leafblad, Prairie Farm; JoEllen Limberg, Iowa City, IA; and Mrs Patrick (Sheila) Barber of Rhinelander.

Harry Gonlag, MD, 61, Eau Claire, died Feb 13, 1985 in Eau Claire. Born Dec 23, 1923 in Harvey, Ill, Doctor Gonlag graduated from Indiana University School of Medicine, Indianapolis, and served his internship at Luther Hospital in Eau Claire. His residency was completed at the University of Wisconsin Hospital in

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Madison. Doctor Gonlag served in the United States Navy during World War II and also in the Korean Conflict. He was affiliated with the Midelfort Clinic for 18 years and was a pathologist at Luther Hospital. He was a former chief-of-staff at Luther Hospital in Eau Claire. He was a charter fellow of the American Academy of Family Physicians, a member of the Eau Claire-Dunn-Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Ruth; a daughter, Mari, Wilmore, Ky; and a son, Dan of Alpine, Calif.

Walter E Clasen, MD, 64, Wauwatosa, died Feb 19, 1985 in Wauwatosa. Born Mar 19, 1920 in Milwaukee, Doctor Clasen graduated from Marquette University School of Medicine and served his internship at St Joseph's Hospital, Milwaukee. His residency was completed at Milwaukee County General Hospital. Doctor Clasen retired from medical practice in 1984. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Lois, and two sons.

Jerry W McRoberts, MD, 79, Sheboygan physician for 38 years, died Feb 20, 1985 in Sheboygan. Born Dec 23, 1905 in Moose Jaw, Saskatchewan, Canada, Doctor McRoberts graduated from McGill University, Montreal in 1929 and served his internship at Royal Victoria Hospital in Montreal. He completed his residency at the Mayo Clinic in Rochester, Minn. After postgraduate studies in European hospitals and schools in 1934-35, Doctor McRoberts returned to the United States and came to Wisconsin where he became a member of the Sheboygan Clinic in 1937. He retired from medical practice in 1975. Doctor McRoberts served in the United States Army Medical Corps in World War II from 1942-45. Active in the State Medical Society of Wisconsin's affairs, Doctor McRoberts served a ten-year term as the Sheboygan County delegate to the Society, became a councilor for the Fifth District, and in 1969 served as president-elect and in 1970 as president of the Society. He was a member of the Executive Committee of the Sheboygan Clinic from 1947 through 1969 serving as president from 1950-54. Doctor McRoberts was president of the Sheboygan County Medical Society in 1953, the St Nicholas Hospital medical staff in 1957, and the Sheboygan Memorial Hospital medical staff in 1950. In 1967 he was elected president of the Wisconsin Division of the International College of Surgeons, the same year he became president of the American Association of Railway Surgeons. From 1969-73, he was a member of the board of directors of the Wisconsin Regional Medical Program. A founder of the Wisconsin Surgical Society, Doctor McRoberts also was affiliated with the American College of Surgeons, The Mayo Foundation, American Geriatric Society, Western Surgical Association, and the American Medical Association. He was a life member of the Pan American Medical Association. Surviving are his widow, Ruth; Two sons, J William McRoberts, MD, and Robert L McRoberts, MD; and a daughter, Mrs Patricia Garton.■

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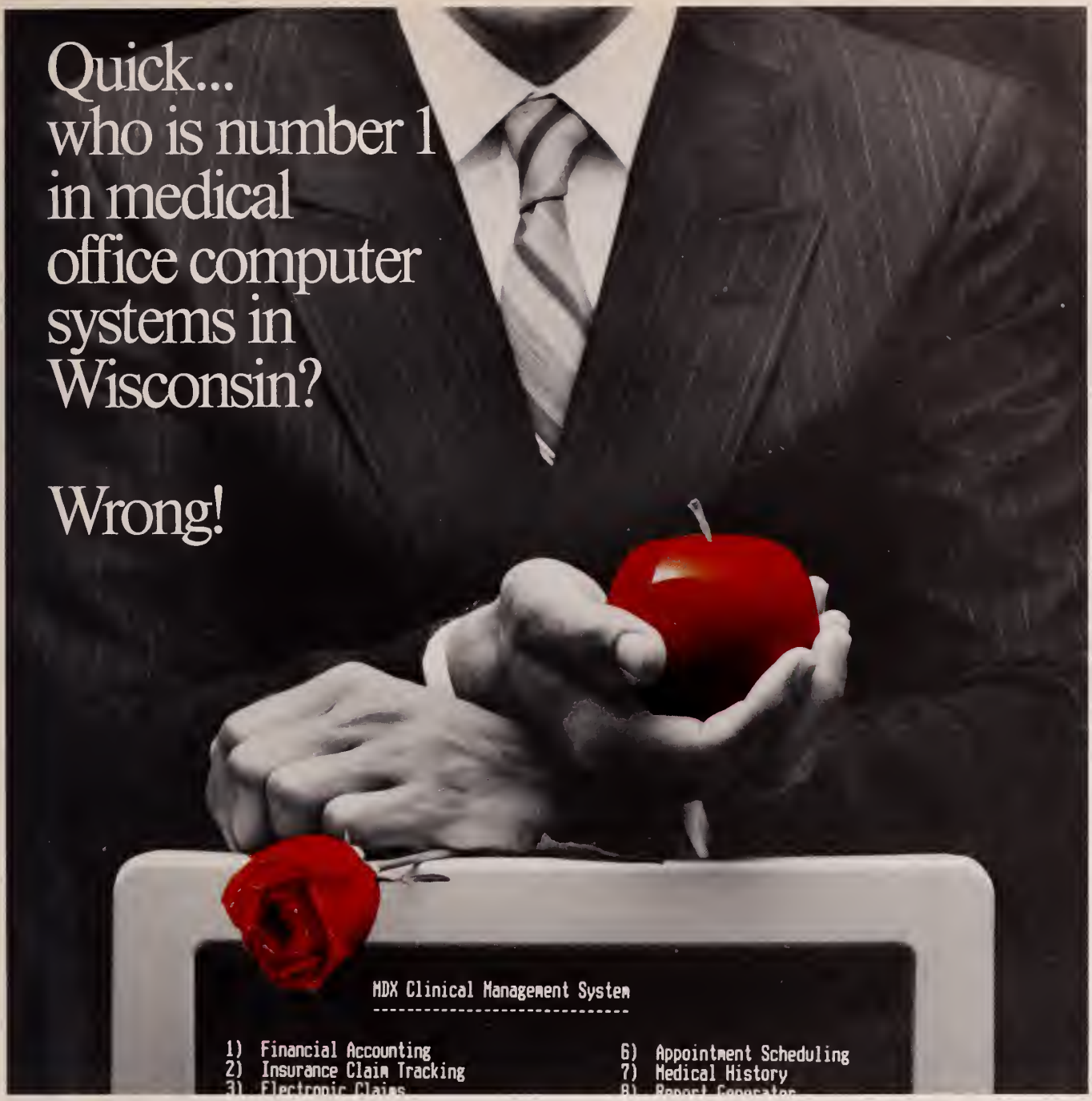

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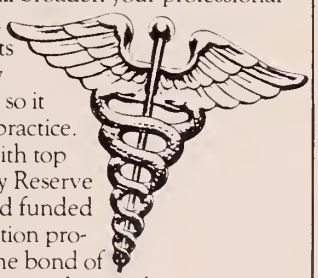

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Phone: 608/263-4095 7/84;6/85

Wisconsin-BC/BE Pediatrician to assume an established position of a pediatrician leaving. Join a three-man pediatric department. Call or write: David L Lawrence, MD, 92 E Division St, Fond du Lac, WI 54935; ph 414/921-0560. p3-8/85

Physicians: US Air Force Medical Corps is currently accepting applicants for physicians in the following specialties: Aerospace Medicine; Orthopedics; Ear, Nose, and Throat; Obstetrics/Gynecology; General Surgeons; Family Practitioners; Internal Medicine, and Pediatrics. For more information call: 414/258-2430. 2-4/85

Staff Psychiatrist. Full-time staff psychiatrist position is available at De Paul Rehabilitation Hospital, Milwaukee, Wisconsin. Board eligible or certification required. Position requires several years of general psychiatric experience with evaluations, differential diagnosis, and treatment of general psychiatric disorders. Sincere interest and/or experience in substance abuse diagnosis and treatment is desirable but not required. Please submit application and curriculum vitae to Dr William McDaniel, Medical Director, De Paul Rehabilitation Hospital, 4143 South 13th St, Milwaukee, WI 53221. 4/85

MEDICAL FACILITIES

Family Practice for sale in Milwaukee. Ideal starter or satellite office. Excellent patient goodwill. Fully equipped and furnished three examining rooms, waiting room, and office. Approximately 900 sq ft. Contact Greg Rodenbeck, DDS, 1200 E Oklahoma Ave, Milwaukee, Wis 53207; 414/481-8111. g10tfn/84

Family Practice office available in south central Wisconsin. Contact Dept 555 in care of the Journal. 4-5/85

For Sale. Like-new medical office furniture for sale—desks, chairs, examining tables, typewriters, file cabinets, x-ray viewers, computer (Victor 9000), and miscellaneous items. Phone 715/369-1261. p4-5/85

Madison, West Side. Hilldale Professional Building. Deluxe office suites, 1200-1700 sq ft. Full service—undercover parking. Call Ralph at office 608/273-5800 or home 608/836-3586. 2tfn/85

MISCELLANEOUS

Physicians Signature Loans to $50,000. Up to 7 years to repay. Competitive fixed rate, with no points, fees, or charges of any kind. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241-6905. 10eom/83

For physicians, hospital administrators

Biomedical ethics conference
June 6–7, American Club, Kohler

Sponsored by State Medical Society of Wisconsin and Wisconsin Hospital Association

For further info contact SMS offices in Madison: Michelle Scoville

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Professionals Insurance Company, The 4
Roche Laboratories . . . . . 81, BC
Dalmane®
S & L Signal Company 73
Smith Kline Beckman 61
Dyazine®
SMS Services, Inc 47
Squibb & Sons, Inc, E R 35, 36, 37, 38
Velosef®
United States Army Reserve 73
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Prevention–Diagnosis–Treatment

Child abuse conference
May 18, Sheraton Inn, Madison

Aimed at physicians in primary care, the conference will address how physicians can work with county social service/protection agencies in dealing with the diagnosis and treatment of child abuse and neglect victims and perpetrators.

Sponsored by the State Medical Society of Wisconsin

For further info contact SMS offices in Madison: Deb Powers

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

MAY 3, 1985: *Adolescents and Substance Abuse,* Conference Center, Mendota Mental Health Institute, Madison. Faculty: Joe E King, MD, Keynote Speaker. Fee: $38. Approved for six hours AMA/PRA Category I credit. Info: Joan Graber, MMHI, 301 Troy Dr, Madison, Wis 53704; ph 608/244-2411. 4/85

MAY 9–11, 1985: Wisconsin Chapter, American Academy of Pediatrics, Pioneer Inn, Oshkosh. g11tfn/84

MAY 9–10, 1985: Methodist Hospital presents its 4th annual *Problem Solving in Emergency Care,* symposium, Madison. Physician, nurse, paramedic and EMT tracks. Tuition: $25–$150. Accreditation: 14 hours AMA Category I, App ACEP Category I. Contact: Mark Olsky, MD (Director), Methodist Hospital, 309 West Washington Ave, Madison, WI 53703; ph 608/251-2371, ext 3015. 3–4/85

MAY 17, 1985; *Plastic Surgery in Primary Care,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

Division of Plastic and Reconstructive Surgery and University of Wisconsin-Extension, Continuing Medical Education. AMA Category 1, AOA, AAFP, University of Wisconsin-Extension CEUs—all 6 hours. Contact: Sarah Aslakson, UW-Extension, Continuing Medical Education, Room 465B, 610 Walnut St, Madison, Wis 53705; ph 608/263-2856. 4/85

MAY 21-22, 1985: *Controversies in Family Medicine: Low Intervention Obstetrics,* Sheraton Hotel, Madison. Sponsored by University of Wisconsin School of Medicine, Department of Family Medicine and Practice and University of Wisconsin - Extension Department of Continuing Medical Education. AMA Category 1, AAFP prescribed, AOA Category 2-D, University of Wisconsin-Extension CEUs—all 11 hours. Contact: Sarah Aslakson, University of Wisconsin, Continuing Medical Education, Room 465B, 610 Walnut St, Madison, Wis 53705; ph 608/263-2856. 4/85

JUNE 3–8, 1985: *18th Annual Postgraduate Course in Gynecological Pathology, Endocrinology, and Maternal-Fetal Medicine,* presented by the Department of Gynecology and Obstetrics of the Medical College of Wisconsin. The course will be held at Olympia Resort, Oconomowoc. The six-day course includes an up-to-date review of endocrinology, maternal-fetal medicine, and cytogenetics in addition to a thorough resume of gynecologic pathology. Registration is limited. Course approved for 46 cognates, Formal Learning, by the American College of Obstetricians and Gynecologists and 46 credit hours, Category I, PRA/AMA. Eighty selected 35-mm slides will be available for purchase to all participants. Contact Richard F Mattingly, MD, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, WI 53226; tel 414/257-5560. p3-5/85

JUNE 6-7, 1985: *Prediction of Drug Levels and Monitoring,* Madison. Sponsored by University of Wisconsin School of Medicine, Department of Medicine and University of Wisconsin-Extension, Department of Continuing Medical Education. Credit: AMA Category 1, AAFP, AOA Category 2-D, University of Wisconsin-Extension CEUs. Contact: Sarah Aslakson, University of Wisconsin-Extension, Continuing Medical Education, 610 Walnut St, Room 465B WARF, Madison, Wis 53705; ph 608/263-2856. 4/85

JUNE 12–15, 1985: *37th Annual Scientific Assembly of the Wisconsin Academy of Family Physicians,* Americana Resort Hotel, Lake Geneva, Wisconsin. Info: WAFP, 850 Elm Grove Road, Elm Grove, WI 53122; ph 414/784-3656. 12/84;1-5/85

JUNE 14-15, 1985: *A Medical and Surgical Review of Reflux Esophagitis and the Angelchik Prosthesis,* Concourse Hotel, Madison. Sponsored by Department of Surgery, University of Wisconsin School of Medicine, and University of Wisconsin-Extension Continuing Medical Education. AMA Category 1 and University of Wisconsin-Extension CEUs, both 11 hours. Contact: Sarah Aslakson, University of Wisconsin-Extension, Continuing Medical Education, Room 465B, 610 Walnut St, Madison, Wis 53705; ph 608/263-2856. 4/85

State Medical Society of Wisconsin
Dates and locations of ANNUAL MEETINGS 1985–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the La Crosse Convention Center.

1985—April 25–27
1986—April 17–19
1987—March 26–28
1988—April 28–30
1989—April 13–15
1990—April 26–28
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

JUNE 28, 1985: *Microcomputers in Medicine,* Milwaukee. A one-day computer seminar and exposition for health care professionals. Topics include choosing a system; office practice management, computer-aided diagnosis. Fee: $50 before May 15 includes admission, lunch, and reception. Info: Micros in Medicine, MCW Libraries, 8701 Watertown Plank Rd, Milwaukee, WI 53226; ph 414/257-8323. g3-4/85

JULY 18–20, 1985: Wisconsin Society of Obstetrics & Gynecology, Olympia Resort, Oconomowoc. g2-6/85

SEPTEMBER 13–14, 1985: Wisconsin Surgical Society, Paper Valley Hotel & Conference Center, Appleton. g2-8/85

SEPTEMBER 13–15, 1985: Wisconsin Society of Anesthesiologists, American Club, Kohler. g2-8/85

Wisconsin Specialty Society Meetings

- Wisconsin Urological Society, April 19-20, 1985, Pfister Hotel, Milwaukee
- Wisconsin Chapter: American Academy of Pediatrics, May 9-11, 1985, Pioneer Inn, Oshkosh
- Wisconsin Academy of Family Physicians, June 12-15, 1985, Americana Resort, Lake Geneva

***

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 25-27, 1985, La Crosse

- Wisconsin Society of Anesthesiologists
- Wisconsin Dermatological Society
- Wisconsin Chapter, American College of Emergency Physicians
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Internal Medicine
- Wisconsin Academy of Ophthalmology
- Wisconsin Otolaryngological Society
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine & Rehabilitation
- Wisconsin Society of Plastic Surgeons
- Wisconsin Society for Preventive Medicine
- Wisconsin Society of Radiation Oncologists
- Wisconsin Surgical Society

OTHERS

JUNE 5–8, 1985 (Alaska): Alaska State Medical Association Annual Convention in Haines. Info: Alaska State Medical Association, 4107 Laurel St, Ste #1, Anchorage, Alaska 99508; ph 907/562-2662. g2-5/85

JUNE 22–23, 1985 (Minnesota): *Management of Common Psychiatric Problems in Primary Care,* Breezy Point Resort, Brainerd. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3-85

AUGUST 1–4, 1985: *Second Annual St Paul-Ramsey Trauma Conference* (Fishing & Family Recreation), Fox Hills Resort, Mishicot. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3/85

AUGUST 1–4, 1985 (Georgia): *International Doctors in Alcoholics Anonymous Annual Meeting.* Hyatt Regency Hotel, Savannah. Reservations may be made at a later date when specific details and instructions are published. For further information contact: Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44511; ph 216/782-6216. g12tfn/84

SEPTEMBER 5–7, 1985 (Texas): American Cancer Society, *Second National Conference on Diet, Nutrition and Cancer,* Shamrock Hilton, Houston. Info: American Cancer Society, Second National Conference on Diet, Nutrition and Cancer, 90 Park Ave, New York, NY 10016. g3-8/85

SEPTEMBER 17–18, 1985 (Illinois): *Medical Practice and Hospital Privileges,* at Chicago Marriott O'Hare, Chicago. Info: American Board of Medical Specialties, One American Plaza, Suite 805, Evanston, IL 60201; phone 312/491-9091. g12/84;1-8/85

1985 CME Cruise/Conferences on Selected Medical Topics—Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20-24 CME Category I credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. ***Fly roundtrip free on Caribbean, Mexican, & Alaskan Cruises.*** Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Info: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 516/549-0869. p9-11/84;1,3,4/85

Symposium on Epilepsy Diagnosis & Management:
May 20, 1985. UHS/Chicago Medical School, Department of Neurology. ***Epilepsy Update: 85.*** Presentors: Drs G Celesia, A V Delgado-Escueta, J A Ferrendelli, R L Macdonald & J Kiffin Penry. For information: Office of Continuing Medical Education, 3333 Green Bay Road, North Chicago, IL 60064. Ph 312/578-3215. ***Fee*** $50. Five credit hours. 4/85

Management of common psychiatric problems in primary care

June 21-23, 1985
Breezy Point Resort
Brainard, Minnesota

Content will focus on newer approaches in the diagnosis and management of psychiatric problems commonly encountered by primary care physicians. Educational format will include lectures, informal discussion, video tape sessions, and "hands on" participation in an interactive computer-assisted program. A variety of recreational and sporting activities including golf, tennis, swimming, boating, fishing, and horseback riding will be available during leisure time, with many points of interest nearby. Sponsored by Dept of Psychiatry and Continuing Medical Education, St Paul-Ramsey Medical Center, St Paul, Minnesota.

Accreditation: 10½ AMA Category I hours, 10½ AAFP prescribed hours.

Information and registration: See info at right

Second Annual St Paul-Ramsey Trauma Conference

(fishing and family recreation)

August 1-4, 1985
Fox Hills Resort
Mishicot, Wisconsin

(Lake Michigan)

This program will combine a high quality educational program with summertime leisure activities on Lake Michigan. The educational component is designed to update physicians on current procedures for initial assessment and appropriate management of adult and pediatric trauma injuries. Time will be set aside for information learning through discussion and videotape sessions. In addition to recreational and sporting activities at the resort, charter fishing will be available on Lake Michigan. Sponsored by Burn Center and Continuing Medical Education, St Paul-Ramsey Medical Center, St Paul, Minnesota.

Information and registration: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, Minn 55101; ph 612/221-3977. 4/85

AMA

JUNE 16–20, 1985: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 8–11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

DOCTOR UNION EXECUTIVE SPEAKS TO DANE COUNTY MEDICAL SOCIETY. Donald C Meyer, DDS, Executive Director, Doctors Council of New York City, a union representing about 3,000 physicians and dentists in that city, spoke to members of the Dane County Medical Society March 27 in a program entitled "Has the Time Come for Doctors' Unions?" Doctor Meyer's answer to the question posed by the program's title was "no;" the time for physicians to unionize came 20 years ago, but that it is not too late to do so now.

Doctor Meyer stated that physicians need a negotiating agent in their increasingly greater role as employes, representation that cannot by reason of law and economics be supplied by medical societies. Doctor Meyer emphasized that unionization is not enough and that physicians must resolve to work together to solve the problems facing most medical practices today.

In response, SMS Secretary Earl Thayer spoke on the history of unions in Wisconsin and the development of the SMS's Physicians Alliance Division over ten years ago as an answer to unionization. SMS Assistant Secretary and Corporate Counsel HB Maroney briefed the audience on the antitrust considerations, namely, that physicians do not necessarily enjoy the same exemption from federal and state antitrust law as do other trade unions. JD Kabler, MD, Chairman of the SMS Commission on Governmental Affairs, completed the speakers' presentations with his cogitations on the subject of unionization from his perspective as a physician employe, manager, and private practitioner. The presentation ended with an informal discussion between the speakers and the audience with SE Sivertson, MD, Vice President (now President) of Dane County Medical Society acting as moderator. ■

AMA GUIDE FOR HOSPITAL MEDICAL STAFF BYLAWS AVAILABLE. Due to the overwhelming demand by hospital medical staffs for guidelines on how to rewrite bylaws to reflect the change in the hospital environment, the AMA developed a monograph entitled "Bylaws—A Guide for Hospital Medical Staffs." This publication can be ordered through the AMA for $15 a copy ($13.50 for AMA members) plus $3.50 handling and delivery by writing:

American Medical Association
Order Department, OP-351
P.O. Box 10946
Chicago, IL 60610

In addition to this AMA guidebook, SMS legal staff reviews hospital medical staff bylaws as a membership service. ■

HAVE YOU BEEN RECEIVING COMPLAINTS FROM PATIENTS ABOUT DRGs? As one of its directives, the SMS Hospital Medical Staff Section is responsible for monitoring DRG implementation in Wisconsin. If you have been receiving complaints from your patients about their own or family member's treatment under the DRG prospective payment system, you can relay this sentiment (preferably written) along to:

State Medical Society of Wisconsin
Hospital Medical Staff Section
P.O. Box 1109
Madison, WI 53701 ■

ALL PHYSICIANS! PLAN TO PARTICIPATE IN THE 1985 PPA CENSUS. In February 1985 all physicians in the US were mailed a Physicians' Professional Activities Census form. Completion of the form assures accurate classification in official AMA records and in the American Medical Directory. The PPA Census is conducted by the AMA every four years for the purpose of identifying the practice specialties and current professional activities of every physician in the country. All physicians—AMA members and nonmembers—are listed in the Directory, as well as those who are no longer in active practice. Not completing the Census form may result in inaccurate classification in AMA records and in the Directory. Moreover, these classifications usually serve as the basis for the distribution of educational information from the AMA as well as complimentary journals and materials from pharmaceutical companies. ■

continued next page

GOVERNOR'S BUDGET BILL. Legislative activity now is concentrated on the budget bill AB 85. Of special importance to SMS is an attempt to change the mandated insurance benefits for mental and nervous disorders. The attempt is to increase the mandatory outpatient benefit from $500 to $1000 and to remove the mandated 30-day inpatient hospital benefit. The bill would require the inpatient benefit for nervous and mental conditions for the lesser of 25 days or $6300. SMS believes the outpatient benefit gives encouragement to "sham" clinics and that the proposed inpatient benefit discriminates against patients who truly need hospital care. Both the SMS and the Wisconsin Psychiatric Association oppose these changes in principle and urge the total elimination of mandated benefits in insurance policies. See further details in the SOCIOECONOMIC section of this issue. ■

ALSO IN THE LEGISLATURE. The Legislature is debating changes in the Capital Expenditure Review (CER) program (successor to Certificate-of-Need). SMS feels that the CER program is no longer necessary in view of the competitive atmosphere and the development of a Hospital Rate Setting Commission. See further details in the SOCIOECONOMIC section of this issue. ■

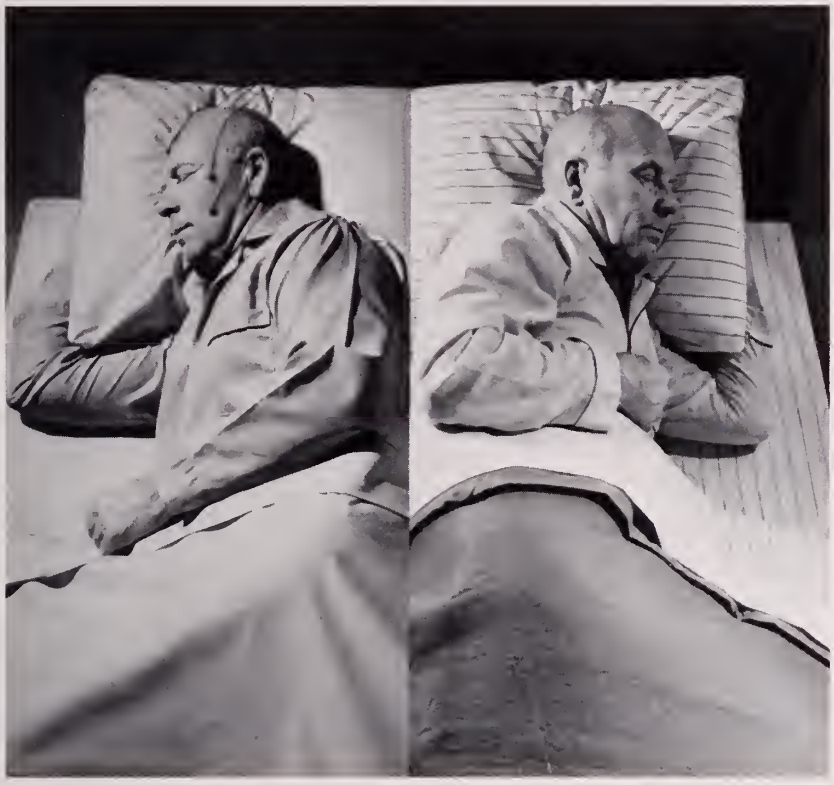
AMA HELPING STATES TRACK PHYSICIAN LICENSING ACTIONS. State licensing boards are now being alerted by the American Medical Association when a physician has had a licensure action taken against him or her in other states. The new procedure identifies physicians who, having been disciplined in one state, may attempt to practice in another jurisdiction where they hold a license. The AMA uses its computerized Physician Masterfile to speed communications among licensing bodies. State boards currently notify the Federation of State Medical Boards (FSMB) in Fort Worth, Texas, of actions they have taken against physicians. The FSMB reports the actions in a monthly summary. Because the FSMB summary lists only the jurisdiction that took the disciplinary action, each state licensing board must review the summary to determine if it has issued licenses to any of the named physicians. Under the new procedure, the AMA checks the FSMB summary against the Masterfile, and informs each state board by letter when one of its licentiates has had his license revoked, suspended, or limited. The AMA Masterfile is the only data base that can identify all the states in which a physician is licensed. "This action is being taken in the wake of national disclosures and concerns regarding credentialing abuses," according to James H Sammons, MD, AMA Executive Vice President. "The AMA is cooperating with the FSMB by providing information to help strengthen the physician credentialing process," Doctor Sammons says. In addition to its collaborative effort with the FSMB, the AMA works with state and federal agencies to identify "physicians" who have obtained their credentials fraudulently, such as individuals who may have picked up the credentials of a deceased physician. Last year, the AMA assisted the US Inspector General in investigations of illegal trafficking in medical credentials, and helped the Educational Commission for Foreign Medical Graduates determine the validity of credentials from three schools in the Dominican Republic. ■

MALPRACTICE CONFERENCE, MAY 10-11, MILWAUKEE, HYATT REGENCY HOTEL. Sponsored by the State Medical Society of Wisconsin, Medical Liability Committee, the conference will focus on how malpractice incidents can be reduced as well as what medical-legal steps can be taken to improve the medical liability situation. Registration: $70 for SMS members; $150 for nonmembers. Further info: SMS staff Deborah Powers, SMS Physicians Alliance Divison. ■

BIOMEDICAL ETHICS CONFERENCE, JUNE 6-7, AMERICAN CLUB, KOHLER. For physicians and hospital administrators, this conference is sponsored by the State Medical Society of Wisconsin and the Wisconsin Hospital Association. For further info contact SMS offices in Madison: Michelle Scoville, Physicians Alliance Division staff. ■

CHILD ABUSE CONFERENCE, MAY 18, SHERATON INN, MADISON. Aimed at physicians in primary care, the conference will address how physicians can work with county social service/protection agencies in dealing with the diagnosis and treatment of child abuse and neglect victims and perpetrators. Sponsored by the State Medical Society. Further info: Deborah Powers, SMS Physicians Alliance staff. ■

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF



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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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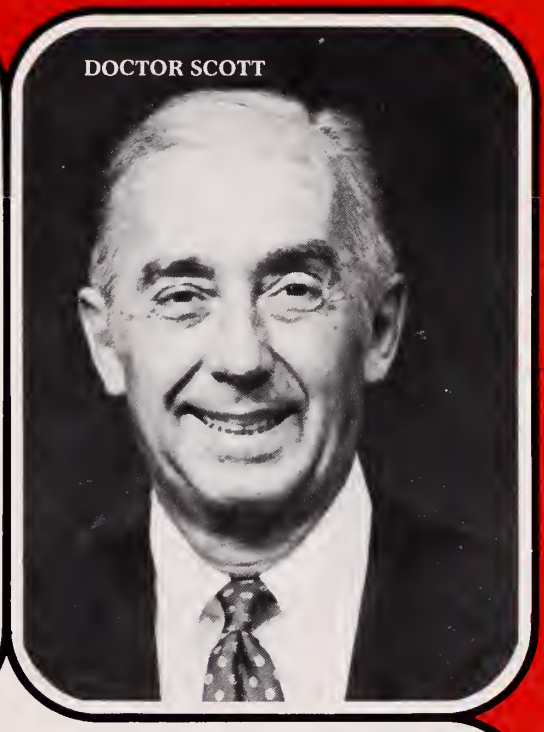
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See pages 4 and 28

MAY 1985

COLLEGE OF PHYSICIANS OF PHILADELPHIA
MAY 29 1985

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CONTENTS

May 1985

SPECIAL FEATURES

President's Page

4 The new president: John K Scott, MD

Editorials

5 Too late
Victor S Falk, MD
Edgerton

5 Some thoughts about "The Fund"
Wayne J Boulanger, MD
Milwaukee

Special

6 AMA Physician's Recognition Award Recipients

23 We are in an era of many changes
Lucille B Glicklich, MD
Milwaukee

38 Statewide pneumoconosis radiologic consultation program begins June 1
State Division of Health

Socioeconomics

43 WISPAC: Some basic rules to follow when writing to your legislator

News you can use

57 Health trends as reported by the National Health Lawyers Association

SCIENTIFIC MEDICINE

7 Outpatient management of chronic pain: long-term results
Sridhar V Vasudevan, MD
Timothy Lynch, MD
Brad K Grunert, PhD
John L Melvin, MD
Stephen E Abram, MD
Milwaukee

10 Hazards of blood and blood products; case report of post-transfusion Hepatitis-B
Charles E Wirtz, MD
John P Kirchner, MD
Patrick M Maloney, MD
Marshfield

11 ABSTRACT: Postoperative surveillance: An effective means of detecting correctable lesions that threaten graft patency
William D Turnipseed, MD
Charles W Archer, MD
Madison

12 Absent serum thyroxine in a hypothyroid man with severe nonthyroidal illnesses
Gary G Wickus, PhD
Robert H Caplan, MD
La Crosse

14 Leptospirosis in Wisconsin: Report of a case associated with direct contact with raccoon urine
Victor S Falk, MD
Edgerton

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Vol. 84, No. 5

CONTENTS

16 Mannitol-induced renal insufficiency
Peter W Gutschenritter, MD
Kermit L Newcomer, MD
Philip J Dahlberg, MD
La Crosse

ORGANIZATIONAL

28 Doctor Scott installed as president; Doctor Landis elected president-elect
29 Membership Directory—Update
36 CES FOUNDATION: Contributions during the month of March 1985

DEPARTMENTS

35 PHYSICIAN BRIEFS
37 NEWS HIGHLIGHTS
38 COUNTY SOCIETIES: Clark . . . Sauk . . . Winnebago
44 OBITUARIES
Joseph D Bonan, MD
Wauwatosa
Gerard J Biedlingmaier, MD
Wauwatosa
Edwin P Bickler, MD
Wauwatosa
Stella I Burdette, MD
Amery
Richard W Farnsworth, MD
Janesville
52 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Miscellaneous . . . Medical Meetings—Continuing Medical Education . . . Advertisers ■

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5600 member physicians in Wisconsin, comprising 55 county medical societies and 25 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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The new president: John K Scott, MD

JOHN K SCOTT, MD, a Madison otolaryngologist, head and neck surgeon, was installed as the 130th president of the State Medical Society of Wisconsin at its Annual Meeting April 25–27, 1985 in La Crosse.

A native of Massillon, Ohio, Doctor Scott is associated with the Madison Ear-Nose-Throat Associates in Madison and is a member of the medical staffs of St Marys, Madison General, and Methodist hospitals, and University Hospital and Clinics, Madison. He is clinical professor of surgery at the University of Wisconsin Medical School and is a preceptor for the fourth-year residency program at Madison General Hospital.

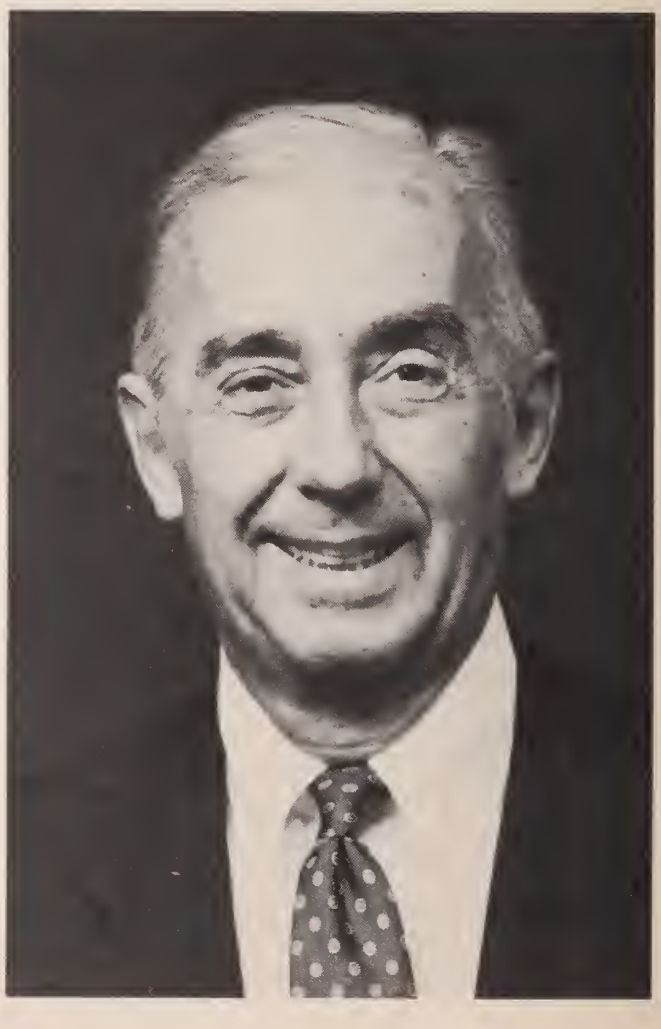
After graduating from Ohio State University College of Medicine in 1954, Doctor Scott served an internship at White Cross Hospital, Columbus, Ohio, and completed his otolaryngology residency at University Hospitals in Columbus. In 1959 he was certified by the American Board of Otolaryngology and became a fellow of the American College of Surgeons.

Doctor Scott has been active in organized medicine at county, state, and national levels. He is a past president of the Dane County Medical Society and has served as a Dane County delegate to the State Medical Society's House of Delegates since 1972. He has participated on several state society committees including serving as chairman of the SMS Committee on Cancer and as a member of the SMS Committee on Medicine and Religion.

At the national level, Doctor Scott has been either an alternate delegate or a delegate to the American Medical Association since 1977, and is currently vice chairman of the Wisconsin delegation to the AMA. In 1984 he served as president of the North Central Medical Conference.

Long interested in the field of cancer, Doctor Scott is a former president of the Wisconsin Division—American Cancer Society, and was a member of the National Board of the American Cancer Society for thirteen years.

He is a past president of the Wisconsin Otolaryngology Society, the Wisconsin Chapter of the American College of Surgeons, and the Wisconsin Professional Review Organization (WIPRO). He also is a member of the Triologic Society, the American Academy of Ophthalmology and Otolaryngology, and the Society of Head and Neck Surgeons.



Doctor and Mrs Scott (Louise) have four children; Susan, Kim, Carol, and Sally. ■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

Too late

THE MARCH ISSUE of the *Journal* included a poignant editorial and an even sadder comment. The subject was in regard to the "rights" of mental patients. Here is another example.

A Sheboygan family sought help for a schizophrenic son. They were told repeatedly that they "would have to wait until he got in trouble with the law."

Well, he stabbed his 75-year-old father to death and wounded his mother. He was then declared by the judge to be "not mentally competent to stand trial."

It was the murderer's "right to refuse help." He had elected to discontinue the medications prescribed for him.

It is too late to help this troubled family, but this example should stimulate changes in legislation to prevent more of these tragedies.
—*Victor S Falk, MD,* Edgerton

Some thoughts about "The Fund"

THERE IS ONLY one topic of conversation for Wisconsin doctors this year. DRGs, which occupied so much attention recently, have been driven into the background. Now the proposed malpractice insurance premium increases occupy all of our attention. We seem to hear two key questions over and over:

1. How is the State Medical Society going to deal with the situation?
2. How is the inevitable increase in the cost of doing business going to be absorbed?

The answer to the first question is easy. The State Medical Society has brought all of its considerable forces to bear upon the problem, disseminating information to its membership and to the public, and working to achieve legislative relief, much as it did ten years ago during the first malpractice crisis. Then, too, there was much emphasis on legislative relief; ultimately the Patients Compensation Fund was created. It seemed at the time to be a logical and fair system, and we all breathed more easily. It took a few years to recognize our mistake. We now find that the Fund has become an albatross which has virtually destroyed solo practice as an option for a surgeon completing his residency or a surgeon who would at age 60 like to cut back his practice a bit.

On March 28 our president, Doctor Flaherty, chaired a meeting of specialty society representatives and county medical society leaders during which those in attendance were briefed by him and by our Physicians Alliance director, Brian Jensen and his staff, detailing the efforts of the State Medical Society in the malpractice arena. All were impressed with the intensity and the quality of the effort expended. And at the end everyone had an opportunity to ask questions and make suggestions. No one left the meeting feeling good about the situation.

After all, time is not on our side. The situation is reminiscent of those old Saturday afternoon movies—if we don't pay off the mortgage by July 1, the bank will foreclose and we'll lose the farm—and we don't have a Little Nell to offer the villain as a bribe, either.

Regardless of what we do, the Fund deficit has to be made up. While there may be some argument with the actuaries as to the amount of the deficit, even the most optimistic prediction places our assessment increase at around 100 percent. Any appeals we make for legislative relief won't change the situation this July 1985, or 1986 for that matter.

There is a Special Committee of the Legislative Council working on medical malpractice. The Medical Society has submitted many recommendations to them designed to secure relief. The committee has indicated support for some of these, and has rejected others. Many have to do with caps on awards, methods of pay out, and so forth. One idea seems promising: to increase the Fund threshold above the $200,000 limit. If the base carrier were responsible for the first $500,000 instead of $200,000, a huge burden would be lifted from the Fund. In the old days of basic coverage and an umbrella provided by the same carrier, the insurance company had a much greater incentive to defend its clients in situations where large awards were a possibility. Today, base carriers are disinclined to offer more than token defense in cases where large awards are likely, since they know their limit is $200,000.

Perhaps the thought ought to be developed even further. What about closing out the Fund altogether? For the next few years we would have to pay off the current awards, but in the long run we would save because:

1. Individual physicians would be free to negotiate their own packages, and premiums would be based on their own track records.
2. Repetitive offenders would be forced out of business without their colleagues having to drag them through torturous peer review mechanisms that have never worked.

But what if private insurance companies back out and umbrella

coverage isn't available? That won't happen, but if it did, we would all have to stop practice, since our hospitals require evidence of adequate malpractice insurance. How long do you think the public would tolerate that? There might be some upheaval for a time, but we would come out ahead in the long run.

Understandably, the level of physician interest in the problem varies depending upon the specialty and the class of risk assigned. Those in the less expensive classes might be tempted to ignore the problem because a 100 percent increase in a $2,000 premium won't break the bank. That security won't last long, though, if that nearly $10,000,000 award against an internist in Green Bay is an indication of things to come.

And no discussion on malpractice in the United States can be complete without comment on the farcical situation in Obstetrics. The anticipated Wisconsin annual premium of $34,613 ought to be an embarrassment to the legal profession and to the courts. One can only hope that the women of this country will get together behind their obstetricians and say: "Enough is enough!" Then rationality will be restored.

—*Wayne J Boulanger, MD,* Milwaukee

Editorial Board comment: *While whole-heartedly in agreement with Doctor Boulanger's comments above, we feel it should be emphasized that other physicians, as well as surgeons, do recognize the medical malpractice crisis and clearly feel its effects if not equally financially, certainly in regard to the previously respected traditions and humanitarian philosophies of medicine. Our devoted and trustworthy patients will ultimately suffer and are beginning to indicate concern. No answers, but great doubts in proposed solutions.* ■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

MARCH

*Abrams, Julian E, Wood
*Beecher, Ann C, Mequon
*Beltran, Luciano R, Elm Grove
*Bodecker, Robert A, Brookfield
*Brown, Jack D, Sparta
*Bulgarin, Nunilo L, Tomahawk
*Buhl, John L, Waukesha
*Clothier, W J Kilburn, Waukesha
*Cody, Edward F, Beaver Dam
*Cowle, Arch E, Verona
*Cummens, Michael L, Genesee Depot
*Damiano, Nicholas F, Hales Corners
*Dibbell, David G, Madison
*Downs, David R, Dodgeville
*Edland, Robert W, La Crosse
*Edwards, Richard W, Richland Center
Eichelman, Burr S, Madison
*Elias, Sharon L, Milwaukee
*Finch, David R, Appleton
*Fownes, Douglas R, Fond du Lac
*Garber, Bradley G, Osseo
*Garman, John S, Waterloo
*Gray, Roger S, Evansville
*Guevara, Esteban, Brown Deer
*Heinzl, Glen J, Oconto
*Heyerdahl, Dan L, Appleton
*Hogan, John P, Milwaukee
*Homburg, Nancy J, Appleton
*Honish, John S, Oconto
*Horwitz, S Fredric, Mequon
Icken, James N, Columbus
*Ives, Donald G, Whitefish Bay
Jackson, Edgar B, Milwaukee
Jefferson, James W, Madison
*Johnson, Robert B, River Falls
Kaufman, Kiesl K, Milwaukee
*Kempthorne, Gerald C, Spring Green
*Kloehn, Ralph A, Wauwatosa
*Knavel, James L, Lake Geneva
*Knier, Michael S, Oshkosh
*Kobelt, Carl C, Manitowoc
*Korkos, George J, Milwaukee
Kretchmar, Joseph S, Milwaukee
*Kuter, David P, Baraboo
*Leasum, Robert N, Osseo
*Mayer, Vicki L, Hudson
*Miller, Owen E, Waukesha
*Milson, Stuart E, Green Bay
*Mol, Henry R, Elkhorn
*Myers, Wilbert E, Fond du Lac
*Nemec, George, Woodruff
*Nietert, William C, Mosinee
*Nogler, Robert A, Baldwin
Offenkrantz, William C, Milwaukee
*Oujiri, John C, Ashland
*Pavelsek, Joseph W, Portage
*Pawlak, James R, Sheboygan
*Pohl, Alan L, Milwaukee
*Pope, George M, River Falls
Reinardy, Michael J, Antigo
Reinighaus, Carl H, Florence
*Ruch, Donald M, Milwaukee
*Salibi, Bahij S, Marshfield
Sanfelippo, Michael, Milwaukee
*Schleper, Albin J, Racine
*Schneider, George R, West Allis
*Schwarz, Robert L, Menomonee Falls
*Skupniewicz, Raymond E, Racine
*Steidinger, Charles L, Platteville
Strube, Roger H, Milwaukee
*Stuff, Patricia J, Bonduel
*Teasley, Jack L, Milwaukee
*Thompson, John E, Nekoosa
*Thompson, Teddy L, La Crosse
Tomlinson, Carol, Janesville
*Towne, Jonathon B, Milwaukee
*Urbanek, Robert E, Beaver Dam
*Vergara, Victorino G, Reedsburg
*Wilkins, Terrence J, Milwaukee
*Williams, Thomas H, Mukwonago
*Wilson, Louis J, Eau Claire
*Wiviott, Wilbert, Milwaukee
*Wright, William E, Mondovi
*Yllas, Santiago L, Racine■

*Members of the State Medical Society of Wisconsin

Have you paid your 1985 membership dues?

Regular member dues of $455 must be paid in full no later than May 15, 1985 to continue as a member. Membership Records as of May 31, 1985 will be used in preparation of the Membership Directory to be published in the July issue. See further details on pages 32 and 33.

Outpatient management of chronic pain: long-term results

Sridhar V Vasudevan, MD
Timothy Lynch, PhD
Brad K Grunert, PhD
John L Melvin, MD
Stephen E Abram, MD
Milwaukee, Wisconsin

ABSTRACT. *An outpatient chronic pain management program utilizing interdisciplinary behavioral and medical treatment has been in operation since May 1977 in a large medical complex setting. Components of this program included multidisciplinary medical evaluation, chemical detoxification, physical, occupational and relaxation therapies as well as group meetings and family therapy. The first 78 patients to complete the program achieved 85% success in eliminating further hospitalization for pain-related complaints for at least one year following treatment. These patients also experienced decreases in self ratings of pain intensity and increases in physical activity and endurance. A one year followup shows many have returned to work and also shows maintenance of improvement.*

Key words: Chronic pain; Pain clinics; Rehabilitation; Outpatient

MUCH HAS BEEN written on the subject of chronic pain and its treatment in the last ten years. Furthermore, much of the literature on pain management has focused on inpatient treatment at a time when nationally, both within health insurance carrier circles and within the medical profession itself, increased emphasis is being placed on outpatient care.[1] The total financial cost of chronic pain in this country has been estimated at nearly $50 billion per year reflecting medical costs, compensation, lost wages, and the like. A significant contribution to these costs is the recent proliferation of inpatient pain management programs. Unfortunately, the long-term efficacy of behaviorally oriented pain programs has yet to be firmly established.[2,3]

Assessment of the effectiveness of pain programs is complicated by the definition of chronic pain itself. Chronic pain is defined as persistent pain of six months duration or longer which has not responded to medical or surgical treatment and for which continued medical/surgical treatment is not considered appropriate.[1,4] These are patients who have continued to have pain despite the best efforts of medical care. They are often unemployed and are dependent upon medications with frequent family stress and associated affective consequences such as depression. Because of the complexity of chronic pain, the need for inpatient pain programs has been emphasized.[1]

Assessment of treatment effectiveness, whether outpatient or inpatient, has frequently focused on the following: medication use, activity levels, and employment.[3] Unfortunately, assessment of the effectiveness of pain management programs has been mitigated by three methodological shortcomings which include: (1) inadequate controls, (2) self selection biases at followup, and (3) the use of questionable dependent measures as well as significant differences in types of treatment. The first two of these criticisms are exceedingly difficult to eliminate for ethical reasons.

METHODS. The first 78 patients to be treated for chronic pain in a rehabilitation program as outpatients at the Curative Rehabilitation Center in Milwaukee, Wisconsin, were studied. The dependent measures utilized to assess effectiveness included: use of medication, physical activity, and employment as well as subjective pain report. The chronic pain management program on an outpatient basis met the standards for accreditation under the criteria outlined by the Commission on Accreditation of Rehabilitation Facilities (CARF).[5] After an initial screening on an outpatient basis by the multidisciplinary team, an appropriate diagnosis was made and appropriate outpatient treatment program prescribed. The program was eight weeks in duration and patients were seen three times each week. None of these patients was treated on an inpatient basis. Patients' subjective assessment of dependent variables was obtained at time of admission and one year after completion of the program.

ADMISSION CRITERIA. Admission criteria for the pain management program were similar to those utilized in other pain programs.[4]

1. Chronic pain of six months duration or more.

From the Department of Physical Medicine and Rehabilitation, Medical College of Wisconsin. Reprint requests to: Curative Rehabilitation Center, Department of Physical Medicine and Rehabilitation, 1000 North 92nd St, Milwaukee, Wis 53226 (SVV). Phone: 414/259-1414. Copyright 1985 by the State Medical Society of Wisconsin.

2. Nonmalignant pain.
3. Inappropriate for further medical/surgical intervention.
4. Observable pain behavior thought to be in excess of organic pathology.
5. Availability of the spouse or significant other person to assist.
6. No psychiatric disturbance of the schizophrenic or delusional nature.

Of the 78 patients referred for pain management, eight were unable to complete treatment but were retained in the followup study. All patients were treated in a multidisciplinary manner as outlined under the pain clinic standards provided by the Commission on Accreditation of Rehabilitation Facilities.[5]

The mean age of patients was 42 years (range of 21-63 years). There were 46 women and 32 men. In 80.5% of these cases, the pain was located in the back area with the remaining percentage being distributed in the head, neck, hip, arms, or legs. Litigation was pending in 21% of the cases, with litigation defined as having retained a lawyer for purposes for pursuing worker's compensation or third-party insurance benefits related to an accident. The average duration of pain was 4.5 years. In all cases an organic basis related to the initial pain complaint. Employment history and work status on admission varied considerably by case and at the time of admission only 19% of the patients were employed either on a part-time or full-time basis.

Medication in the form of nonnarcotic and narcotic analgesics was seen in 92% of the patients. These included muscle relaxants, nonnarcotic analgesics, and tricyclic antidepressants.

PROGRAM DESCRIPTION. The program is located at the Curative Rehabilitation Center, an outpatient rehabilitation facility, part of the Milwaukee Regional Medical Complex. All patients were evaluated by a physiatrist (specialist in physical medicine and rehabilitation), and correctable medical as well as surgical problems were ruled out. Patients were admitted after an evaluation by a team including physical therapist, occupational therapist, social worker, and psychologist. All patients admitted to the program received the services three half days per week for eight weeks. The following were the stated major goals:

1. Decrease subjective pain.
2. Increase physical activity levels.
3. Reinstate employment.
4. Decrease use of non-essential medications.

Treatment consisted of physical conditioning in occupational therapy as well as physical therapy focusing on increased sitting and standing tolerance, increased activity levels, increased endurance, and understanding of their illness and application of proper body mechanics in daily living activities. Psychological approaches included cognitive coping instruction, group therapy, breathing techniques, relaxation, and biofeedback training. Social service contact dealt with education of other members of the family with regard to principles of chronic pain management. Medication reduction was accomplished through weekly titration done voluntarily by the patient. Medication detoxification did not utilize the "pain cocktail."[4] The home program activities constituted a major aspect of treatment in that patients were given exercise quotas to be performed at home as well as additional exercises to be performed under the supervision of therapists on an outpatient basis. Home programs also included walking quotas, exercise quotas, and home relaxation training. Medical staffing with the interdisciplinary team to discuss the patient's progress was held upon initiation of the program, at midpoint and upon discharge. Staff treating these patients regardless of disciplinary orientation cooperated in treatment and exchanged information on patients' progress under an administrative management system referred to as matrix management. All patients were given basic instruction in the principles of pain management as well as educational lectures on the uses and abuses of medication and the role of the family in rewarding pain behaviors. Staff was trained to ignore pain behaviors and reward healthy behavior.

RESULTS. Variables analyzed in this study consistent with the objectives of the program included subjective pain ratings, employment status, and use of medications. The means for each of these variables at pretreatment and one year followup appear in Table 1.

The data were analyzed by means of a multivariate analysis of variance (MANOVA). This allowed for the comparison of the pretreatment and followup profiles at a given level of significance using pre- and posttreatment scores as a repeated measurement variable. The results of the MANOVA were significant ($F = 4.457$; $P < .01$). Significant differences were found between the pretreatment variables profile and the followup variables profile as shown in Table 1.

As indicated in Table 1, the patient's subjective report of pain perception on a behaviorally anchored 10-point scale decreased from 8.3 to 5.4 indicating a significant improvement at followup. Similarly, the number of patients employed increased significantly from a pretreatment

level of only 19% to more than 50% at followup. Medication usage was reduced from 92% to 45% and was also significant at the 0.01 level.

DISCUSSION. Data collected for this outpatient pain management program compare favorably with outcomes of inpatient treatment. There was a significant reduction in subjective pain perception, but more importantly there was an increase in employment reflecting the overall activity level of the patient. Medication reduction is often one of the major reasons for inpatient treatment. In that, it is apparent from the data collected that outpatient treatment may not be as successful as inpatient with regard to medication reduction. However, further long-term followup studies on these patients will be necessary to adequately compare inpatient versus outpatient treatment.

Admittedly "very few chronic pain patients are ever cured, most having learned to manage their pain."[1] Given the cost comparisons between outpatient and inpatient if outpatient treatment can approximate the results of inpatient care, it would seem appropriate to choose the former except in those cases where significant medication abuse/dependence, excess pain behavior, or out-of-town living arrangements require consideration.

Table 1: *Comparison of pretreatment and followup data*

	Pre-treatment	Followup
Pain (0-10 subjective scale)	8.3	5.4*
Employment (% employed)	19.0%	52.0%*
Medication (% utilizing nonnarcotic and narcotic analgesics)	92.0%	45.0%*

*P < .01

The advantages of outpatient treatment for the management of chronic pain are that of low cost, brief duration, and use of the outpatient setting. Such programs permit the patient and the family to work actively on making changes in the home environment and responding differently to pain behaviors, while the patient is still actually in the home. Previous research has emphasized this aspect of outpatient treatment and noted that patients in outpatient programs do not consider themselves "sick" and can continue their usual activities and perhaps more easily generalize their newly learned focus on healthy behavior.[6]

All studies reporting long-term results of chronic pain management programs have limitation of being retrospective and lacking control groups. Furthermore it is difficult to ascertain which of the multiple treatment modalities used in interdisciplinary treatment programs is responsible for the changes that occur.

The results mentioned above indicate a degree of success in the treatment of persistent pain on an outpatient basis, but many further questions are left unanswered. Additional experience and investigation of longer followup is still needed. In addition, future studies should include detailed planning and followup with regard to efforts to promote generalization and maintenance of treatment. Adequate planning for generalization of treatment results is most likely to effect long-term maintenance and should be included in future studies.

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Consensus on tuberculosis treatment

Public health officials should be provided with the legal means to confine noncooperative sputum-positive tuberculosis patients at public expense, according to a consensus report appearing in the April *Archives of Internal Medicine.* Developed by a national conference on tuberculosis, the report identifies high-risk groups, including newly arrived immigrants, nursing home residents, and nursing home and hospital employees. It recommends continued surveillance of these groups, but says surveillance of the general community should be discontinued, including chest x-ray screening programs. Treatment of choice is a nine-month regimen of isoniazid and rifampin, supplemented by ethambutol, streptomycin sulfate or pyrazinamide. ■

Hazards of blood and blood products
Case report of post-transfusion Hepatitis-B

Charles E Wirtz, MD
John P Kirchner, MD
Patrick M Maloney, MD
Marshfield, Wisconsin

ABSTRACT. *Post-transfusion Hepatitis-B is now an infrequent sequela to transfusion of blood and blood products in central Wisconsin; however, it still occurs frequently enough that screening for post-transfusion Hepatitis-B is warranted. A case is discussed in which a patient acquires post-transfusion Hepatitis-B from the transfusion of a single unit of packed red blood cells. It is evident that the use of the radioimmunoassay for Hepatitis-B surface antigen and the elimination of donors from lower socioeconomic groups has had great impact on the reduction of the disease. The use of "risk free" blood and blood products has not contributed as much as originally thought to the reduction of the disease. It is imperative all possible post-transfusion hepatitis patients be evaluated.*

Key words: Transfusion; Hepatitis-B; Single unit

POST-TRANSFUSION Hepatitis-B is now a rare sequela to transfusional blood and blood products.[1] The following is a case discussion of post-transfusion associated Hepatitis-B that demonstrates the difficulty in the prevention of this particular malady.

CASE REPORT. A 67-year-old white male underwent mediastinoscopy in April 1982 for bilateral hilar adenopathy. Postoperatively the patient did well, and in August of 1982 the patient presented with jaundice, weakness, and malaise. Transaminases done at that time showed an aspartate transaminase (AST) of 1761 (normals 8-36), gamma glutomyl transferase (GGT) of 238 (normals 0-62), total bilirubin of 25.5 with 20.5 units being unconjugated (normals 0-1.3), and glutamic pyruvic transaminase (GPT) of 1230 (normal 0-32). A hepatitis screen was performed which demonstrated Hepatitis-B surface antigen and antiHepatitis-B core antibody in the patient's serum. Physical examination was remarkable for the patient's severe jaundice; however, no other abnormalities were noted.

Upon interviewing the patient, the only risk factor for Hepatitis-B infection elicited was the administration of one unit of packed red blood cells during his mediastinoscopy.

COMMENT. Our patient presents one of the rare cases of post-transfusion associated Hepatitis-B at the Marshfield Clinic. Hepatitis-B post-transfusion hepatitis accounts for about 10% of post-transfusion hepatitis[2] and it is frequently anicteric and asymptomatic.[3]

Efforts at decreasing post-transfusion Hepatitis-B are aimed at secreting donor blood for evidence of contamination with Hepatitis-B or using "low risk" blood products for transfusion. Screening of donor blood by using a radioimmunoassay sensitive for Hepatitis-B surface antigen has improved the ability of blood banks to reject units that are positive for Hepatitis-B surface antigen.[4] Yet, Cossant, et al[5] demonstrated three cases of post-transfusion Hepatitis-B from blood that was negative by radioimmunoassay for Hepatitis-B surface antigen. To detect contaminated blood, Lander, et al[6] advocated the use of screening for antiHepatitis-B core antibody in addition to surface antigen screening. Other authors[7] also have noted that the use of antiHepatitis-B core antibody screening of donor units would result in fewer cases of non-A, non-B post-transfusion hepatitis as well.

Another factor in the reduction of post-transfusion Hepatitis-B is the gradual elimination of commercial donors. However, as pointed out by Aach,[1] one cannot assume blood products are entirely without risk just because they are drawn from "volunteer" donors. In particular, Aach[1] felt that the socioeconomic status of the donor was more important than the volunteer or nonvolunteer status of the donor unit of blood. He concluded careful selection of donors rather than blind reliance on volunteers should be emphasized.[1]

Also used to decrease the incidence of post-transfusion Hepatitis-B is the use of "low risk" blood products. Prebil,[8] in 1974, described 100 patients who received no whole blood during coronary artery bypass graft surgery and received only washed red blood cells and synthetic plasma expanders. In these patients he documented no cases of post-transfusion hepatitis. However, Haugen,[9] in 1979, documented cases of post-transfusion Hepatitis-B in which the patient received only frozen or washed

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cells. Thus, both whole blood and packed cells carry the risk of transmitting post-transfusion associated Hepatitis-B.

Autologous transfusion also can be considered low risk. It has been shown to decrease the risk of post-transfusion associated Hepatitis-B.[10] However, because of the low inherent risk of post-transfusion associated Hepatitis-B, it has not become as popular as expected.

The use of immune serum globulin and Hepatitis-B immune globulin has been investigated in regards to prophylaxis of post-transfusion hepatitis. Knodel[11] found a benefit from gamma globulin for prophylaxis for post-transfusion hepatitis; however, Conrad[2] and Mintz[12] recommended gamma globulin only for patients exposed to known Hepatitis-B surface antigen contaminated products and do not recommend it for routine transfusion prophylaxis.

Other donor risk factors which increase post-transfusion associated hepatitis include the use of first-time donors, use of donors between the ages of 20 and 50, use of male donors, and use of black and Oriental donors, regardless of sex or age.[3] It is interesting to note the risk for post-transfusion associated Hepatitis-B is independent of the volume of blood or blood products transfused if this blood is derived from volunteer sources.[1]

Although the advent of blood transfusion has saved innumerable lives in the past, it is not without risk. The above case and discussion show that while post-transfusion associated Hepatitis-B has been decreased, it has not been eliminated from the practice of medicine in central Wisconsin. Practitioners should suspect transfusion associated hepatitis in any patient exposed to blood or blood products with elevated transaminases post-transfusion. It is also important for the practitioner to report any case of suspected post-transfusion associated hepatitis so the appropriate donors can be screened and eliminated from the donor pool.

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ABSTRACT

Postoperative surveillance: An effective means of detecting correctable lesions that threaten graft patency

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Thirteen patients with recurrent ischemia following previous vascular surgery and 13 patients with primary ischemia were prospectively evaluated with segmental Doppler pressure indices and selective intravenous digital subtraction angiography. Ten patients with recurrent postoperative ischemia had thrombosed bypasses, and three had stenosed but patent grafts. Eight (62%) of the 13 patients had successful vascular repair, the rest had amputations. All patients with previous vascular surgery and those with primary bypasses were prospectively followed up with segmental Doppler pressure indices. Falling segmental Doppler pressure index values occurred in eight patients and in six patients prior to onset of recurrent ischemia. Intravenous digital subtraction angiography demonstrated correctable stenotic lesions in the six asymptomatic patients and untreatable host vessel occlusion in two symptomatic patients. Corrective surgery successfully preserved patency of all stenosed grafts. In summary, postoperative surveillance can detect occlusive changes before recurrent symptoms occur. Repair of stenosed grafts is more successful than repair of occluded grafts. ■

Absent serum thyroxine in a hypothyroid man with severe nonthyroidal illnesses

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ABSTRACT. *We studied a hypothyroid patient with severe postoperative complications. Thyroxine therapy was discontinued after surgery. After the onset of the critical nonthyroidal illnesses, the patient's thyroxine fell more rapidly than expected to undetectable levels. The institution of intravenous thyroxine therapy did not produce the anticipated rise in serum thyroxine. Since the metabolism of iodothyronines can be markedly altered during nonthyroidal illnesses, we suggest that hypothyroid patients should have frequent measurements of serum thyroxine performed during serious nonthyroidal illness.*

Key words: Hypothyroidism; Thyroxine therapy; Iodothyronine metabolism in nonthyroidal illness

PATIENTS WITH A variety of nonthyroidal illnesses have decreased levels of thyroxine (T_4), 3,5,3'-triiodothyronine (T_3), and the respective free hormone indices.[1,2] These patients display normal levels of thyrotropin (TSH) and are believed to be clinically euthyroid. A low thyroid hormone status, however, which may initially be adaptive may eventually compromise cellular function.[3] We report herein a hypothyroid patient in whom the serum T_4 concentration rapidly fell to undetectable levels after he developed critical postoperative complications. Intravenous thyroxine therapy did not result in the expected increase in serum T_4.[4]

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CASE REPORT. After coronary artery bypass surgery a 69-year-old diabetic man suffered multiple pulmonary emboli and developed *Staphylococcus aureus* infections of the incision, pleural space, and blood. On the 8th postoperative day he sustained a cardiopulmonary arrest and developed persistent hypotension, progressive renal failure, and hepatic failure. Despite treatment with dopamine infusions, renal hemodialysis, and other intensive supportive measures, his clinical status progressively deteriorated.

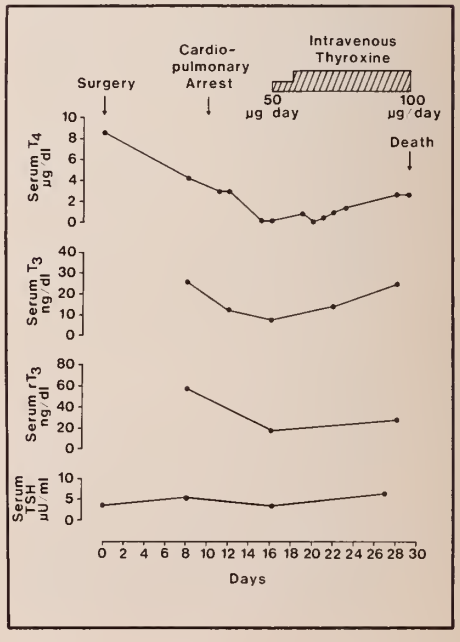
Two years prior to coronary artery bypass surgery the patient's serum T_4 was 3.2 μg/dL (expected range, 5.0-12.5 μg/dL) and the serum TSH was 27 μU/ml (expected range, 0-9 μU/ml). A diagnosis of primary hypothyroidism was made, and he was treated with oral thyroxine (0.15 mg/day). On the day of surgery he was clinically euthyroid, and his T_4 was normal (Fig 1). Thyroxine was not restarted immediately after surgery. Fifteen days after surgery we could not measure serum T_4 (minimum detectable level, 0.1 μg/dL).

A retrospective analysis of preserved serum samples revealed that a rapid drop in T_4 concentration occurred between the 12th and 15th postoperative day (Fig 1). We added known amounts of thyroxine to samples of the patient's serum which contained no detectable hormone, and total recovery of the added thyroxine confirmed that the absence of thyroxine in the patient's serum was not an artifact due to an interfering agent.

Postoperatively, the serum T_3 concentration (expected range, 75-165 μg/dL) also dropped to almost undetectable levels, and rT_3 (expected range, 5.8-19.4 μg/dL) was elevated (Fig 1). Except for values of 57% and 51% on the days when T_4 was not detectable, the T_3 uptake values ranged from 47% to 50% (expected range, 34-44%).

The serum albumin fell from 4.2 to 1.9 g/dL during his illness, but the level of the thyroxine

Figure 1—*Effects of severe nonthyroidal disease on serum levels of thyroxine (T_4), triiodothyronine (T_3), reverse triiodothyronine (rT_3), and thyrotropin (TSH) in a hypothyroid patient without thyroid hormone replacement. Hormone levels after intravenous administration of thyroxine are also shown. Expected ranges: T_4, 5.2-11.2 μg/dL; T_3, 75-165 μg/dL; rT_3, 5.8-19.4 μg/dL; TSH, 0-9 μU/ml.*



binding globulin remained within normal limits (13 μg/ml; expected range, 12-28 μg/ml). Serum TSH remained within the expected range (Fig 1).

From the 16th postoperative day the patient was treated with intravenous thyroxine; the rise in serum iodothyronines (Fig 1) was modest and less than expected.[4] Because of the patient's moribund condition, we were not able to judge clinically his thyroid status. He died on the 29th postoperative day.

DISCUSSION. Patients with a variety of nonthyroidal illnesses frequently show reductions in the serum T_3 concentration resulting from impaired T_4 to T_3 conversion[1,2] The diminished 5′-monodeiodination of T_4 often results in an elevation of rT_3. Severely ill, often moribund patients may also display reductions in serum T_4.[1,2,3] The mechanism for T_4 reduction in critically ill patients is not completely known. The reduction of T_4 binding proteins present in our patient was not sufficient to produce the marked reduction of T_4. The more rapid than expected decline of T_4 in our patient suggests accelerated T_4 clearance, a mechanism demonstrated by others in severely ill patients with the low T_4 syndrome[5,6] The less than expected rise in T_4 during intravenous thyroxine therapy is also consistent with increased T_4 clearance as a cause of the undetectable T_4 in our patient. Dopamine infusion substantially reduces serum TSH and thereby T_4 and T_3 secretion in both euthyroid and hypothyroid patients[7] and probably also contributed to the low levels of iodothyronine concentrations in our patient.

The T_3 uptake values were not markedly elevated as might be expected if an inhibitor of T_4 binding to serum proteins was present.[8] Falsely low T_3 uptake values that do not reflect the altered state of serum T_4 binding, however, may be caused by serum T_4 binding inhibitors that also prevent the ability of the secondary binding agents in the T_3 uptake assay to bind T_3.[2]

The therapeutic implications are not clear. Lowered thyroid hormone concentration in a previously euthyroid patient may represent, at least at early stages, an adaptation to severe illness, and some authorities do not recommend thyroid hormone treatment.[2] On the other hand, as the amount of thyroid hormone falls to extremely low levels, even euthyroid patients may suffer detrimental effects on cell function.[3] We believe that hypothyroid patients should have frequent serum T_4 measurements performed during serious nonthyroidal illness, especially if thyroxine supplementation is temporarily stopped. Further studies, however, are needed to determine whether hypothyroid patients during severe illness would benefit from larger than usual replacement doses.

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Leptospirosis in Wisconsin: Report of a case associated with direct contact with raccoon urine

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ABSTRACT. *Two cases of leptospirosis were reported in Wisconsin in 1984. The confirmed case, reported here, was attributed to raccoon urine being precipitated into the patient's upturned face. Leptospirosis is a worldwide zoonosis. The initial phase is characterized by headaches, severe muscular aches, chills, and fever. Fever and meningismus may occur with the second phase. Weil's syndrome is a form of severe leptospirosis with jaundice and usually azotemia, hemorrhages, anemia, disturbances of consciousness, and continued fever. Man is actually an accidental host, becoming infected through occupational exposures, invasion of wildlife environment, and through close contact with infected pets. All mammals are capable of becoming infected. The diagnosis in this case was established serologically at the Centers for Disease Control in Atlanta.*

Key words: Leptospirosis; Weil's syndrome

ONLY TWO CASES of leptospirosis were reported in Wisconsin in 1984. Information from the State Division of Health indicates that a probable case occurred in a laboratory worker in Madison who contracted the disease from a dog. The confirmed case, reported here, was attributed to a definite exposure to raccoon urine. There were also two cases diagnosed in dogs at the school of Veterinary Medicine at the University of Wisconsin-Madison in 1984.

Leptospirosis is a worldwide zoonosis. The term includes all infections due to organisms of the genus *Leptospira,* and 130 to 150 serotypes have been identified. Leptospires are spirochetes and thus are related to Trepanema pallidum. Leptospirosis is found in several domestic and wild animal hosts, and the disease varies from a minor illness to fatal outcome. Animals may become carriers and shed leptospires in their urine for months. Human infections may result from direct contact with an infected animal's urine or tissue or indirectly by contact with contaminated water or soil. Minor skin lesions and mucous membranes and conjunctivae are the common portals of entry in man. It can occur at any age, but 75% of those infected are males. It is seen as an occupational disease particularly among farmers, sewer workers, slaughterhouse workers, veterinarians, and others with frequent exposure with animals; but most commonly exposure is accidental in recreational activities. Dogs, rats, and swimming in contaminated water are regarded as the most frequent sources. From 25 to 145 cases are reported annually in the United States and these occur mainly in summer and autumn.

The incubation period varies from 2 to 20 days and the disease is usually in two phases. The leptospiremic phase comes on suddenly with headaches, severe muscular aches, chills, and fever. This may last four to nine days with recurrence of chills and fever. After abatement of fever the second or immune phase occurs from the 6th to 12th day. It is then the antibodies appear in the serum. Fever and meningismus may then recur.

Weil's syndrome is a form of severe leptospirosis with jaundice and usually azotemia, hemorrhages, anemia, disturbances in consciousness, and continued fever. Renal abnormalities result in proteinuria, pyuria, hematuria, and azotemia. Hemorrhagic manifestations are due to capillary injuries. Hepatic damages are minimal, and complete healing usually occurs. There is no mortality in anicteric patients, but with the occurrence of jaundice the mortality is about 15%. This rate is doubled in patients over 60 years of age.[1]

CASE REPORT. This 22-year-old white male came to the emergency room at the Edgerton Hospital late in October 1984. He complained of headache, anorexia, photophobia, nausea and vomiting, and episodes of hematemesis. This had begun earlier that same day and became progressively worse. The initial impression was that he had an acute viral syndrome and he was given erythromycin and sent home. The following day he called to report that his temperature was up to 104 F (40 C) and that he had a stiff neck and backache. Hospitalization was advised but he declined at that time. However, the next day he returned to the emergency room because of worsening of the symptoms including diffuse myalgia, abdominal tenderness, and one episode of hematuria. He then reported that several days

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prior to admission he had been bitten by a wild raccoon he was carrying in a burlap bag and also that he was exposed to raccoon urine. It was subsequently learned that the contact with the raccoon urine was prior to the capture of the raccoon when it was still in the tree, and it had urinated into the upturned face and mouth of the patient.

Backache was so prominent a symptom when he was first seen that the physician in the emergency room had ordered x-ray studies of the lumbo-sacral spine. These were read as normal along with a normal chest x-ray film. Because of the patient's severe frontal-parietal headache and stiff neck when he returned, a lumbar puncture was done in the emergency room. The spinal fluid was reported as being entirely normal.

The laboratory returns were interesting and significant. When the patient was initially seen in the emergency room, his white blood cell count was 4,200 per cu mm with 60 segmented neutrophils and 7 band forms. On admission the WBC count was up to 8,200 per cu mm with 65 segmented neutrophils and 17 band forms. The urinalysis showed only a small amount of occult blood, 1-3 RBCs and 15-20 WBCs per high-power field and 1 + bacteriuria. However, a repeat urinalysis showed 4 + urobilinogen and was positive for bile. The chemistry panel was significant for serum glutamic-oxaloacetic transaminase of 106 (7-27), lactic dehydrogenase of 162 (50-134), total bilirubin 4.9 (0.2-1.5), serum glutamic-pyruvic transaminase 114 (7-30), alkaline phosphatase 230 (26-99), and globulin of 3.5 (1.5-3.0). (Normal values are in parentheses).

Intravenous fluids were started as the patient was quite dehydrated, and he was given injections of prochlorperazine (Compazine®) and meperidine hydrochloride (Demerol®) for nausea and pain. Intravenous cefazolin sodium was also started. Hepatitis A and B were considered, but there was no serologic evidence of either.

Three weeks later his chemistry panel returned to normal except for a slightly elevated alkaline phosphatase. At the same time, the serum was sent to the Centers for Disease Control in Atlanta. Using the Microscopic Agglutination Test, it was positive for three serovars of leptospirosis whereas the serum from three weeks before was entirely negative. The positive antigens were *L. carcicola* (200), *L. grippotyphosa* (1600) and *L. djasiman* (3200). This was considered diagnostic for leptospirosis.

The patient recovered uneventfully and returned to work.

DISCUSSION. Leptospirosis is a common zoonotic disease of livestock, pet animals, and wildlife in the United States. Man is an accidental host that becomes infected through occupational exposures, through invasion of wildlife environment, and through close contact with infected pets. The human infection is exhausted within itself, and it is only in extremely rare instances that it is the cause of fresh cases of the illness. Apparently all mammals are capable of becoming infected. In a survey in Detroit almost 40% of stray dogs were found to have significant titers for leptospiral agglutinins and 92% of the rats were infected. Other surveys showed a large number of wildlife hosts involved in all regions of the world. Death resulted in sea lions off the coast of California when the sea lions contacted infected surface water on land. It also has been estimated that in the United States 15% of the cattle, or 18 million, and 8% of the swine, or 5 million, would be positive reactors. This would be even higher in Central and South America where the disease is more extensive.

Because of the widespread presence of leptospires and the possible exposure to humans, physicians must consider leptospirosis in the differential diagnoses which would include meningitis, meningoencephalitis, influenza, hepatitis, acute cholecystitis, and renal failure. Treatment is with antibiotics and penicillin is recommended. Tetracycline is the alternative for pencillin-allergic children under eight years of age. Fluid and electrolyte therapy is necessary for azotemia or jaundice. Isolation is not required since nosocomial transmission has not been reported, but care must be taken in disposing of the urine.

The Editorial Board encourages other physicians to submit interesting and informative case reports such as this one.

Prevention of leptospirosis is difficult because of the extensive reservoirs in nature. Hygienic measures in occupational sites are necessary for those working with animals. Protective clothing is recommended for those in contact with water and soil potentially contaminated with animal urine. Rat control programs and the immunization of livestock limit major animal reservoirs. Swimming in contaminated water should be avoided. Prevention by the annual leptospiral immunization of dogs is of limited value since the vaccine contains only two serovars.[2]

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Mannitol-induced renal insufficiency

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ABSTRACT. *We present a case of a young woman who suffered a cerebrovascular occlusion and developed marked intracranial hypertension. After large doses of mannitol were administered, the patient developed acute renal failure which resolved when the mannitol was discontinued. We hypothesize high dose mannitol administration can induce acute renal failure.*

Key words: Mannitol; Acute renal failure

MANNITOL IS AN osmotic diuretic commonly used for the treatment of increased intracranial pressure. We have recently treated a young woman who suffered a cerebrovascular occlusion and subsequently developed elevated intracranial pressure. She developed acute renal failure associated with mannitol intoxication. The renal failure resolved after discontinuation of the mannitol.

CASE REPORT. A 23-year-old white female was brought to the emergency room after she was found unresponsive. She was a two-pack-per-day smoker and was taking oral contraceptives.

On examination she was awake but unresponsive to questioning. She exhibited a flaccid right hemiparesis and vigorously moved her left extremities. A computed tomographic scan of the brain showed a large area of decreased density in the left frontotemporal region. Carotid arteriography demonstrated complete occlusion of the left internal carotid artery. She was not felt to be a surgical candidate. The patient was treated with 4 mg dexamethasone intravenously every four hours. Serum creatinine on admission was 0.8 mg/dL.

On the 3rd day of her hospitalization, she deteriorated neurologically. She was unresponsive to painful stimuli and showed no movement of any extremity. A computed tomographic scan of the brain was repeated and demonstrated a shift of the midline to the right and marked cerebral edema. Subsequently, the heart rate dropped to between 30 and 40 beats per minute, but intraarterial blood pressure monitoring showed maintenance of systolic blood pressure at 120 mmHg. An intracranial pressure monitor was placed and initial readings were between 40 and 50 mmHg. The patient was intubated and hyperventilated. Intravenous mannitol was prescribed at 20 Gm every two hours. When the intracranial pressure failed to respond to these doses, the dose was increased to 60 Gm of mannitol every hour. On the 4th hospital day she received a total of 1,095 Gm of intravenous mannitol. Over the next several days the patient demonstrated no improvement in her neurologic status.

On the 8th day the patient's urine output dropped to 14 ml per hour and the following laboratory studies were obtained: serum creatinine 5.2 mg/dL, serum sodium 127 mmol/L, serum potassium 6.3 mmol/L, serum chloride 98 mmol/L, serum carbon dioxide 18.6 mmol/L, urine sodium 20 mmol/L, urine creatinine 48 mg/dL; serum osmolality was 412 mosm/kg and urine osmolality 398 mosm/kg. The calculated osmolality* was 87 mosm/L less than measured osmolality and the estimated mannitol concentration was 1583 mg/dL.** The mannitol was discontinued and intravenous furosemide was given. Brisk urine output resumed and the patient's weight dropped 5.2 kg over the subsequent two days. On the 10th day, serum creatinine had fallen to 2.1 mg/dL. Serum sodium rose to 161 mmol/L. Urine osmolality was 754 mosm/L at this time.

At this point her clinical examination showed no evidence of neurologic activity. An electroencephalogram confirmed the diagnosis of brain death. Respiratory support was withdrawn and the patient died on the 10th day.

DISCUSSION. Temporally this patient's episode of acute renal failure was related to severe mannitol intoxication. Acute tubular necrosis secondary to decreased perfusion is unlikely in the face of normal continuous intraarterial blood pressure readings, a fractional excretion of sodium of 1.7, and no clinical evidence of vol-

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*Based on the formula:

$$2[Na] + \frac{[glucose]}{18} + \frac{[BUN]}{2.8} = \text{serum osmolality.}$$

**The calculation assumes the 87 mosm/L gap is accounted for by mmoles/L of mannitol. The molecular weight of mannitol is 182 mg/mmole. Therefore, the estimated concentration of mannitol is:

$$\frac{87 \text{ mmoles/L} \times 182 \text{ mg/5mmole}}{10 \text{dl/L}} = 1583 \text{ mg/dL.}$$

ume depletion. Other medications received during her hospitalization included 10 mg diazepam intramuscularly four times daily, 10 mg dexamethasone intravenously every four hours, 60 mg codeine intramuscularly every six hours and 30 ml Maalox per nasogastric tube every four hours. Resolution of her renal failure promptly followed withdrawal of the mannitol and administration of furosemide. The abrupt rise in serum sodium concentration after discontinuing the mannitol can be attributed to the diuresis of water in excess of sodium and the shift of water from the extracellular space into the intracellular space.

The infusion of hyperosmotic agents and their effects on the renal parenchyma have been studied by several authors.[1,2,3,4] The most consistent finding is swelling and vacuolization of the cells lining the proximal convoluted tubules. These changes have been induced in laboratory animals using mannitol as well as other hypertonic infusions. Dalgaard and Pedersen[5] confirmed similar changes in man when they performed a renal biopsy on a man three hours after mannitol infusion. None of these authors relates a decline in renal function to these histologic changes. Dextran 40, a high molecular weight plasma expander, has been associated with renal failure in some patients.[6,7,8] Histologically, vacuolization of the tubular epithelial cells has been noted. However, dextran 40 causes a very viscous urine and some authors feel that tubular sludging and obstruction may account for the renal insufficiency seen in these patients.

We hypothesize that vacuolization and its relationship to renal function lies on a continuum. The excessive doses of mannitol used in our patient may have caused a degree of tubular change that compromised renal function. The renal impairment was rapidly reversed by stopping the drug.

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Multiple biopsies linked to metastases

Multiple biopsies of pancreatic tumors increase the risk of rapid intra-abdominal spread of tumor, researchers from the Thomas Jefferson University Hospital in Philadelphia report in the April *Archives of Surgery.* Stephen M Weiss, MD, and colleagues, say they reviewed 62 patients with pancreatic cancer undergoing repeat laparotomy to identify risk factors associated with metastases. "Patients who underwent two or more operative biopsy procedures were at a markedly increased risk of developing intra-abdominal tumor seeding," they say. Among alternative diagnostic procedures they suggest is percutaneous fine-needle aspiration biopsy assisted by computed tomography.■

Recurrent genital herpes a trivial disorder

Genital herpes simplex virus infection can be viewed essentially as a trivial disorder, "causing patients minor physical discomfort and some alteration in the pattern of their normal sexual activity," writes Stanley M Bierman, MD, FACP, of UCLA School of Medicine, in the April *Archives of Dermatology.* While it can threaten a fetus at term, "the simple clinical fact remains that the disease is a benign, self-limiting infection for most healthy individuals," he adds. Unfortunately, this is not how most affected inidividuals view the affliction, and psychosocial issues associated with herpes infection have made it much more difficult to manage than it should be, he suggests.■

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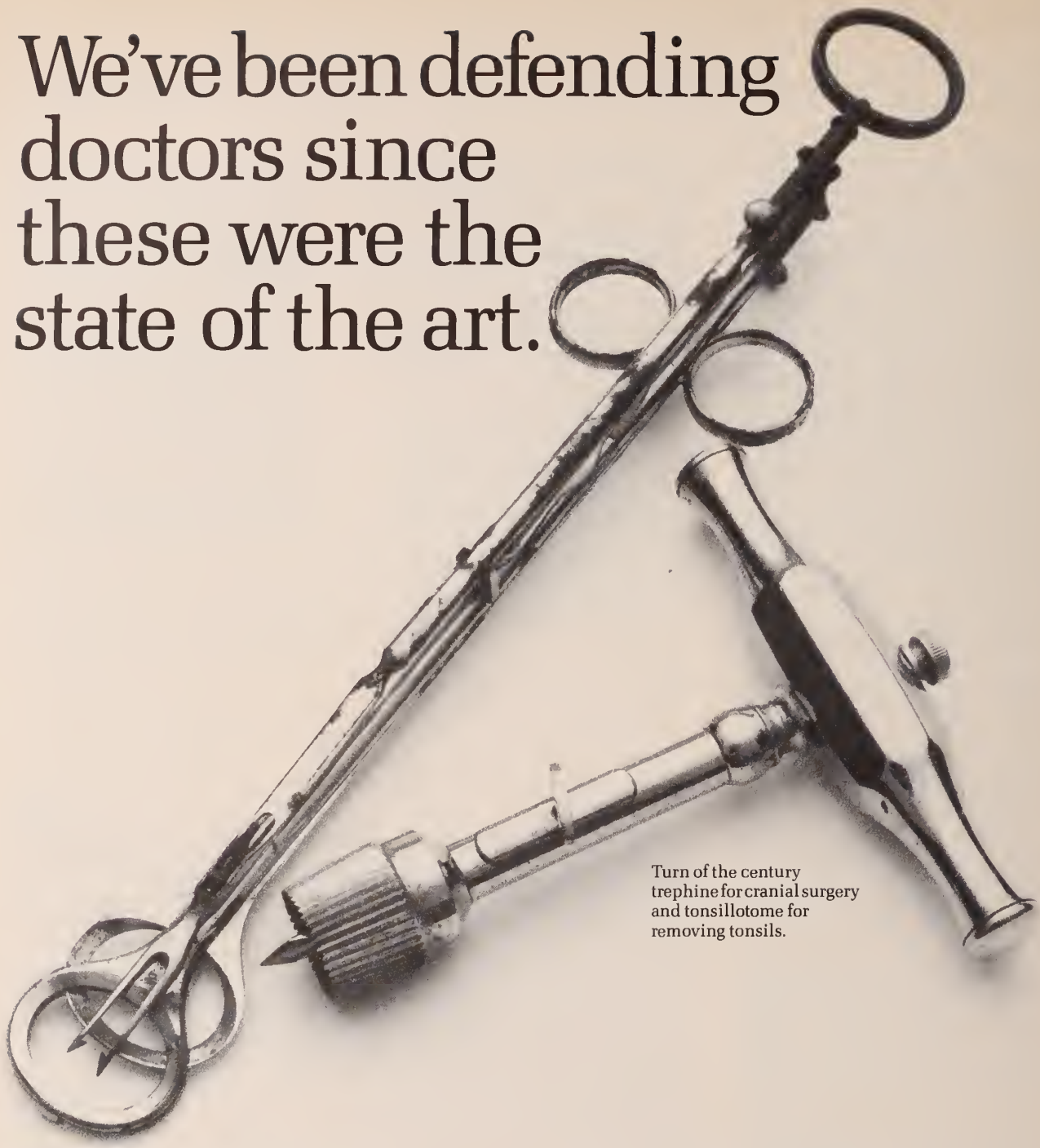

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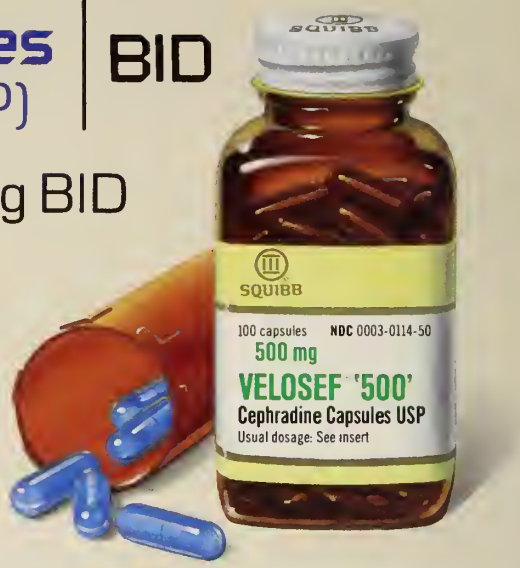

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bifirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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We are in an era of many changes . . .

Lucille B Glicklich, MD, Milwaukee

IT'S AN HONOR to stand here as your first woman president—it' s a change. We are in an era of many changes—dramatic, rapid changes which have taken the physician from an autonomous private practice of two or three decades ago to the present day when the physician is a member of the health industry—the second largest industry in the country employing millions of people and involving billions of dollars. We could speculate as to whether this was progress or regression but it would be to no avail because this is where we now are.

For a long while we mourned the physician who was long on compassion, courage, and patience but had little sophistication and knowledge of the ways of modern medicine and technology. Today our physicians are long on knowledge and skill but we find ourselves deficient when it comes to the realms of management, marketing, competition, joint ventures, and all which comprise the world of business.

Doctor Glicklich, first woman president in the history of the Medical Society of Milwaukee County, presented this installation address at the 138th Annual Meeting of the Society, January 17, at the Milwaukee Athletic Club in Milwaukee.

Lucille B Glicklich, MD

No longer can we view ourselves as the only purveyors of healthcare but are partners in a system which consists of hospitals, nurses, administrators, dentists, pharmacists, third party payors, business, labor, industry, and government, to mention a few. We are all interested in serving the patient-client-customer as the case may be, and all of us are interested in good outcomes. We are all also interested in fair and adequate reimbursement. We may, however, have different definitions of what is a good outcome and what is fair and adequate reimbursement. We may find many areas in which our roles as individualist physicians who practice for the individual needs of our patients are threatened. We find ourselves forced into standards of practice which are dictated by government regulation and by the third parties who are responsible for paying the bills for our services. It makes us very uncomfortable that our patient's welfare may depend upon decisions made by nonphysicians.

When faced with such knotty problems, I find it helpful to go back to basics and try to clarify the issues from the standpoint of 3 "Rs." These are Reality, Responsibility, and Respect. Let us first look at Reality. It is clear that for the time being, the present governing and controlling forces will neither diminish nor disappear. If anything, they will increase and multiply.

Second, we have become part of the business and money world and as such we have a great deal to learn from our partners in the health industry. It is difficult for us to think in terms of business and money because of the implication that perhaps we are not interested in the welfare of our patients. At the same time it is a reality that we have invested heavily in our education and do expect to be paid for our services. We have, however, come a long way from the day when physicians were paid directly by the patient. The third reality is that our patients have become customers of third-party payors and we no longer deal directly with our patients. With the advent of the HMOs, IPAs, etc, we have learned that we must negotiate, compromise, and accept contracts for service at fees which are less than are usual and customary.

The fourth reality is that we have come into a world of competition, another foreign land for those of us trained in medicine. New words have come into our vocabulary, words which are unusual and uncustomary such as marketing and advertising. We find ourselves competing for patients with our colleagues on the basis that we can offer services for less money. The advent of walk-in clinics and surgical centers has given the concept of competition a vastly new look.

The fifth reality is that we may have to scrutinize the way in which we practice medicine and

may have to change. I am referring to the theories of variations in practice style proposed by John Wennberg and quoted by Representative Richard Gephardt. This theory states that medicine is practiced differently in different areas. The variation in practice styles has been extensively studied and data are available which show that there is considerable cost difference in various locales. That is to say that a specific condition treated in one area may entail greater cost than when that same condition is treated in another geographic area. This is a matter which needs further study and Doctor Sammons believes as does Doctor Wennberg that such studies could best be conducted by organized medical societies. The advent of the DRGs makes such studies particularly important.

> *"No longer can we view ourselves as the only purveyors of healthcare but are partners in a system which consists of hospitals, nurses, administrators, dentists, pharmacists, third-party payors, business, labor, industry, and government, to mention a few."*

A sixth reality is that physicians may become involved in joint ventures with hospitals. To quote Glenn Richard, prospective pricing is putting hospitals at risk for the cost of care, but physicians determine most of resource consumption. Thus, physicians are needed by the hospitals. On the other hand, physicians need hospitals for the care of their patients because they are part of the HMO package and because low-cost alternative providers threaten to take away both hospital and physician business. This places both physicians and hospitals in a negotiating stance because organization is a necessary tool of efficient operations and such is available in hospitals. On the other hand, hospitals are dependent on the physician for patient supply and must give up total control of how hospitals are used. Joint ventures such as those in Minnesota and Texas, etc are of note and may be portends of things to come in any community.

No discussion of reality is complete without reference to our ever-present boogy-man—the threat of malpractice. We are aware that we will continue to have malpractice crises with escalating costs until we either bankrupt the system or legislate some changes. The contingency payment system for lawyers presents serious problems. We have complained about this and have developed referenda decrying the practice—to no avail. We have decried the huge awards, even when no negligence is cited —to no avail. It is true that there is another side to the coin—the public needs representation even when there are no "up-front" friends—if there has been malpractice. It is also true that reasonable restitution should be made for pain and suffering. It is also true that we need to be protected from frivolous, painful legal suits. There are three parties all fighting for their truths. Somehow we must negotiate; we must cooperate. Sometimes we must confront and then return to negotiate more. This is one of our "nuclear weapon" type of problems. The only role is negotiation because the alternative is self-destruction.

The second "R" is Responsibility. There is little question but that our primary responsibility is to our patients. We are responsible to deliver the highest quality of care. At the same time, we are faced with the responsibility to contain costs.

It is absolutely essential that we work with third party payors toward mutual understanding. Some of the obvious cost-saving devices and maneuvers are penny-wise and pound-foolish (example), whereas others are wise and judicious. Both physician providers and third-party payors may have to change old established patterns for the benefit of all.

As we grapple with this, we also have the responsibility to consider means to provide medical care to the uninsured, the unemployed, and the indigent without medical assistance.

Programs such as the Share-Care concept are a start in this direction. Donation of physician services, however, is only one piece of the total medical needs, and we must cooperate with other medical and social services to meet this void.

As members of hospital staffs we have responsibilities to support those institutions while, at the same time, we are endeavoring to keep costs down by decreasing hospital days.

Physicians must increase their line of communication with hospital administrators and Board of Directors. Together we must explore innovative joint ventures which expand quality services at nominal costs.

Responsibility to our profession and to each other is obvious. This may be one of the more difficult areas because it touches on peer review which may be viewed as spying on each other—it refers to testifying in court which may be viewed on turning against each other and involves recognition of the fact that physicians are human and may become impaired for many reasons. We need to find ways in which

we can become more comfortable and more adequate in addressing these problems.

Patients have the ultimate responsibility for their bodies. There is only one issued per person. Spare parts are hard to come by and are not guaranteed. Patients have long been bringing their bodies to us saying "you're the doctor" implying that the responsibility for health and well-being was ours. In part, we may have encouraged that, implying that the body was ours and we were leasing it to them as long as they would return to us for maintenance and repairs. It is time all patients (not just the women of the feminist movement), all people take back their bodies and assume good dietary and exercise routine, examine themselves for various warning signs, be aware that failure to cope is as much a disorder as bleeding, monitor drug/alcohol use, and above all, presume life and health.

As we are in the process of educating, we have responsibility to educate our partners in the health industry about our profession, our strengths, limitations. At the same time, we must learn about these—the nurses, dentists, pharmacists, administrators, etc. In the future, not so distant, we will together be found with the prospect of rationing of care and the responsibility of allocating the health dollar. We will need to do this in cooperation with our other health industry professions.

The top of this list is self-respect.

Somehow this is being threatened by the advent of preauthorization and DRGs. We have all heard and experienced some "horror story" about a patient who was refused treatment or hospital admission because of rules and regulations imposed by one of the "alphabet groups" such as HMOs, WiPRO, or Medicare. We do not want to be conned into becoming liars merely to accommodate the Procrustian bed of the DRGs. We may be forced and tempted to do so on behalf of our patients or to obtain payment for services or admission to hospitals. It is important that as a group we confront the power structure and advocate the rights of our patients to appropriate individualized decisions.

> *"Self respect . . . Somehow this is being threatened by the advent of preauthorization and DRGs . . . It is important that as a group we confront the power structure and advocate the rights of our patients to appropriate individualized decisions."*

Second on our list is respect for the patient, and there is much which can be said but most of it is obvious for that is what medicine is all about. Respect is preserving the mental and physical welfare of the patient during life and in the process of death.

Respect of colleagues is the third on the list and goes hand in hand with what I said in regard to responsibility.

Earlier I made the point that our practice cohort now includes many allied healthcare professions and also business, labor, lawyers, administrators, etc. It is important that we make great efforts to understand these partners. Out of understanding grows patience, tolerance, and, ultimately, respect. We all have much to offer each other but these offerings will not be accepted unless we respect the givers.

Last, but most difficult is our need to respect the Systems in which we find ourselves.

It is on this note that I would like to go into my final remarks. All the preceding rhetoric is of no avail if we cannot seek some solutions. That which I have said has been iterated far more eloquently and colorfully in the various Doctor's lounges and offices throughout this country. Often, however, the last line is that nothing can be done and that we are glad we shall be retiring in another few years since Medicine has changed so much it is not any longer a satisfying profession.

This is equivalent to picking up our marbles and going home. Actually, from the standpoint of technology and knowledge, we are in the most exciting moments of medical history. Our ability to help patients make their lives productive and useful has never been greater. It is true that there are numerous barriers which have been erected between these medical advances and our patients, but they are not insurmountable. It is true that our knowledge often presents more problems than it solves—(ethical, emotional). We must view these as challenges and have hope that solutions can be found.

This may mean that we must compromise, that we must negotiate, that we must take some financial losses, and that we must learn many new rules. Although third parties are paying medical costs, we must insist on physician input to their formulas. This we might accomplish through legislation, negotiation with insurance groups, and through citizen action. If our

> *"The Medical Society must become the instrument for change rather than the last bastian for the victims of change. It is only through coordinated, informed effort that the positive step I've alluded to can take place. We must encourage honest, dedicated, outspoken membership which is willing to act rather than just complain and capitulate."*

patients learn about the limitations of their plans and accept responsibility for both health and health costs, they can become useful allies in changing the shape of the third-party contracts.

Through legislative action we can contain our burgeoning malpractice costs. Here we will need much help from our state government officials and in utopia from the legal profession.

Through considerate and compassionate quality assurance measures such as utilization review, peer review, incidence reporting, etc, we can improve the practice of medicine and make it more effective. We need active physician participation in all these hospital activities.

These solutions may sound like platitudinous rhetoric. We have sounded off long enough. Now is the time for each of us to take time to pay attention to the problems, to seek solutions, to go out into the wide community which has become the extended medical community to learn about that community and to work toward mutual goals. We must learn to listen to and understand our friends and our adversaries and we must try to help them to understand us and most important, the needs of our patients.

We must encourage those patients to use the medical system economically and to report our problems to us, the Medical Society. Individually we can do a great deal, but ultimately, it is the organized medicine group.

The Medical Society must become the instrument for change rather than the last bastian for the victims of change. It is only through coordinated, informed effort that the positive step I've alluded to can take place. We must encourage honest, dedicated, outspoken membership which is willing to act rather than just complain and capitulate. Our leadership must be willing to listen to dissenters for many have good, rationale ideas which may be unpopular but worthy of trial.

This next year, during my tenure in office, I plan to make many excursions into the community, to become better acquainted with our "partners in medicine," and to help them to understand and to cooperate with our efforts to bring good medicine to all. I stand open to your ideas and encourage you to take an active role in our Society. Tell me where you want to grow, and we shall accommodate you.■

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Members of record at May 31, 1985 will be included in the 1985 MEMBERSHIP DIRECTORY to be published in the July issue of the *Wisconsin Medical Journal*. Members are urged to watch their mail for the MEMBERSHIP RECORDS VERIFICATION FORM which will be used in preparation of the Directory.

See pages 32 and 33 for further details.

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No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

Winthrop-Breon

© 1984 Winthrop-Breon Laboratories

Please see following page for Brief Summary.

Talwin® Nx (IV)

Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone

TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions: Usage with Alcohol.* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility.* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C.* Should be given to pregnant women only if clearly needed. *Labor and Delivery.* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular.* Hypotension, tachycardia, syncope. *Respiratory.* Rarely, respiratory depression. *CNS Acute CNS Manifestations.* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects.* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal.* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic.* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic.* Visual blurring and focusing difficulty. *Hematologic.* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other.* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

Please consult full product information before prescribing.

Winthrop-Breon

WIN 4-41415FR

Winthrop-Breon Laboratories
Division of Sterling Drug Inc.
New York, NY 10016

Doctor Scott installed as president; Doctor Landis elected president-elect

John K Scott, MD of Madison was installed as the 1985-86 president of the State Medical Society, succeeding Timothy T Flaherty, MD of Neenah, during the 130th Annual Meeting April 25-27 in La Crosse.

Charles W Landis, MD of Milwaukee was elected president-elect.

Duane W Taebel, MD, La Crosse, was reelected vice speaker of the House of Delegates. John J Foley, MD, Menomonee Falls, was reelected treasurer.

Reelected to serve as delegates to the AMA for 1986 and 1987 were Henry F Twelmeyer, MD, Wauwatosa; Richard W Edwards, MD, Richland Center; and Cornelius A Natoli, MD, La Crosse. Timothy T Flaherty, MD, Neenah, was elected a delegate for 1985.

Reelected to serve as alternate delegates to the AMA for 1986 and 1987 were J D Kabler, MD, Madison; Kenneth M Viste Jr, MD, Oshkosh; and Richard H Ulmer, MD, Marshfield. John P Mullooly, MD, Milwaukee, was elected an alternate delegate for 1985 and 1986, and Charles W Landis, MD, Milwaukee, was chosen to serve as an alternate delegate for 1985.

The House also confirmed the election of 11 physicians to the Society's Board of Directors. Reelected to the Board were: Jerome W Fons Jr, MD, Milwaukee; Cyril M Hetsko, MD, Madison; J D Kabler, MD, Madison; James J Tydrich, MD, Richland Center; Jung K Park, MD, Wisconsin Rapids, and Darold A Treffert, MD, Fond du Lac. Elected to the Board were Glenn H Franke, Milwaukee (succeeding John P Mullooly, MD, Milwaukee); Lucille B Glicklich, MD, Milwaukee (succeeding Charles W Landis, MD, Milwaukee); Kenneth I Gold, MD, Beloit (succeeding Allen O Tuftee, MD, Beloit); Joseph C DiRaimondo, MD, Manitowoc (filling the vacancy created by the resignation of Irvin L Schroeder, MD, Plymouth, last year); and Philip J Happe, MD, Eau Claire (an additional director for the Seventh District).

Other elections and appointments will appear in the June BLUE BOOK issue.

A full summary of the House of Delegates action will appear in the June BLUE BOOK issue. ■

Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1984 Membership Directory as published in the July 1984 issue of the *Wisconsin Medical Journal*. Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership records. County transfers will be included when processing has been completed by the Membership Department.

New, reelected, or reinstated members
(complete information)

Changes in specialties and/or Board certification(*)
(changes only with member's name)

By county medical society

BROWN

GP
Manabat Jr, Enrique S
812 South Fisk St
Green Bay WI 53404

DANE

CDS TS*
Adib, Khosro
345 W Washington Ave
Madison WI 53703

EM IM*
Beckfield, Paul W
104 Oak Court
Verona WI 53593

N PN*
Britton, Daniel E
345 W Washington Ave
Madison WI 53703

IM*
Bridgwater, Gary R
3713 Milwaukee St
Madison WI 53714

EM IM*
Bowman, H Michael
B4/341 UW CSC
600 Highland Ave
Madison WI 53792

OTO EM
Campbell, David A
1125 Rutledge St, #2
Madison WI 53703

Chu, Paul
1530 Adams St
Madison WI 53711

IM OPH
Danis Jr, Ronald P
600 Highland Ave
Madison WI 53792

EM* PD
Erskine, C Peter
718 Oneida Pl
Madison WI 53711

D
Falk, David K
345 W Washington Ave
Madison WI 53703

AN*
Galvez, Timoteo L
POB 5367
Madison WI 53705

EM
Geurkink, Terry F
1675 Bartlett Ct
Belleville WI 53508

OTO
Haberman II, Rex S
717 Bruce Ct
Madison WI 53705

EM FP*
Holt, Michael C
5021 Regent St
Madison WI 53705

FP*
Hunter, Merle A
1 South Park St
Madison WI 53715

P
Jackson, Robert D
345 W Washington Ave
Madison WI 53703

EM
Jacobson, Steven M
1307 Wyldhaven
Monona WI 53716

DR R*
Jensen, Steven R
600 Highland Ave
Madison WI 53792

FP*
Kamnetz, Sandra A
5001 Monona Dr
Madison WI 53716

PD*
Katcher, Murray L
1130 Shorewood Blvd
Madison WI 53705

OBG
Kauma, Scott W
600 Highland Ave
Madison WI 53792

FP* OBG
Keepman, Jay P
3602 Atwood Ave
Madison WI 53714

CHP P
Little, Margaret L
5534 Medical Circle
Madison WI 53711

PD*
Luyet, Francois M
345 W Washington Ave
Madison WI 53703

IM
March, Andrew W
3301 Harvey St, #L
Madison WI 53705

IM*
Mc Aweeney, William J
345 W Washington Ave
Madison WI 53703

FP* EM
Meyer, Thomas D
707 South Mills St
Madison WI 53715

OBG FP
Mullins, Maureen A
345 W Washington Ave
Madison WI 53703

Nettum, James C
2152 Fox Ave
Madison WI 53711

ORS*
Niedermeier, William R
2 West Gorham St
Madison WI 53713

GS
O'Grady, Martin G
600 Highland Ave
Madison WI 53792

FP*
Olinger, Mark B
5001 Monona Dr
Madison WI 53716

CDS IM*
Orie, Judith E
H6/339 UW CSC
600 Highland Ave
Madison WI 53792

IM
Rohbins, Mark L
7345 Century Pl
Middleton WI 53562

Rosenblatt, Amy M
2924 Harvey St, #58
Madison WI 53705

AN
Schroeder, Mark E
B6/373 UW CSC
600 Highland Ave
Madison WI 53792

Semans, Bruce E
POB 9872
Madison WI 53715

OTO GS
Shaikh, Arif J
2060 Allen Blvd, #30
Middleton WI 53562

N
Shewmake, Karl E
345 W Washington Ave
Madison WI 53703

FP*
Soderquist, Catherine
777 South Mills St
Madison WI 53715

PD*
Staats, Patricia V
345 W Washington Ave
Madison WI 53703

GS
Vega, Roland J
345 W Washington Ave
Madison WI 53703

continued

DANE *continued*

EM FP*
Young-Szabo, Cheryl J
7846 W Oakbrook Circle
Madison WI 53717

DODGE

FP*
Timmermans, Peter W
200 E Main St
Waupun WI 53963

DOUGLAS

Doyle, Thomas J
2626 Ogden Ave
Superior WI 54880

FOND DU LAC

HEM IM*
Frick, Jacob C
80 Sheboygan St
Fond du Lac WI 54935

ORS*
Smith, Donald A
480 E Division St
Fond du Lac WI 54935

GRANT

IM PUD
Gaither, James M
525 North Wisconsin
Muscoda WI 53573

ORS
Mokrohisky III, Stephen M
4513 Gregg Rd
Madison WI 53705

MANITOWOC

IM
Holder, Lynn W
601 N 8th St
Manitowoc WI 54220

MARATHON

FP*
Moore, Jeffrey L
1924 Eva Rd, #14
Mosinee WI 54455

FP
Rosas, Steven L
995 Campus Dr
Wausau WI 54401

MILWAUKEE

FP*
Adrouny, Salpi
6901 West Edgerton
Milwaukee WI 53220

EM FP*
Anderson, Dennis
2900 W Oklahoma Ave
Milwaukee WI 53215

Austin, Renate
2720 N Frederick Ave, #130
Milwaukee WI 53211

FP
Azcueta, Renato S
8120 N Mohawk Ave
Fox Point WI 53217

OBG*
Babbitz, Allen H
1218 W Kilbourn Ave
Milwaukee WI 53233

Barrow, Linda J
10416 Fisher Parkway
Wauwatosa WI 53226

CD IM
Becker, Michael D
4184 N Bartlett Ave
Milwaukee WI 53211

Benzer, David G (DO)
4385 Rainbow Ct
New Berlin WI 53151

DR R*
Bond, Jeffrey R
8901 W Lincoln Ave
West Allis WI 53227

P*
Currier, George E
2445 North 91
Wauwatosa WI 53226

IM
Dongas, Barbara S
4443 N Frederick Ave
Shorewood WI 53211

PTH* CLP
Eisenstein, Reuben
950 N 12th St
Milwaukee WI 53201

D*
Engel, Charles J
5203 Roberts Dr
Greendale WI 53129

AN
Fingard, David H
4870 North Lake Dr
Whitefish Bay WI 53217

AN
Francis, Michael C
2825 N Mayfair Rd
Milwaukee WI 53222

Gillis, Rick D
3462 North 97th St
Milwaukee WI 53222

Gregory, James S
2092 S 102nd St, #314-A
West Allis WI 53227

IM* PUD
Hanson, James C
2901 W KK River Parkway, #516
Milwaukee WI 53215

EM IM
Harkins, Heidi J
2610 N Murray Ave
Milwaukee WI 53211

GS* CDS
Heber, David L
2040 W Wisconsin Ave, #422
Milwaukee WI 53233

Heger, Jiri
1221 N 70th St, #4
Wauwatosa WI 53213

EM IM*
Hendley, Gail E
2819 N 55th St
Milwaukee WI 53210

D
Jerofke, Alfred
2505 Almesbury Ave
Brookfield WI 53005

FP
Kalman, Maryann M
4224 W Villard St, #13
Milwaukee WI 53209

Karos, Michael G
2825 N Mayfair Rd
Milwaukee WI 53222

GS
Kispert, John
2524 N 124th St
Wauwatosa WI 53226

La Crosse, Larry E
212 High St
Port Washington WI 53074

FP EM
La Roque, Charles A
2900 W Oklahoma Ave
Milwaukee WI 53215

PM
Lerner, Jerome A
2024 E Marion St
Shorewood WI 53211

FP*
Mc Daniel, William P
4517 North Frederick
Whitefish Bay WI 53211

FP
Mc Sorley, Brian R
1721 W Oklahoma Ave
Milwaukee WI 53215

Merrill, David C
222 W Hampton Ave, #308
Milwaukee WI 53217

FP
Moody, Timothy J S
3830 W Rawson Ave
Franklin WI 53132

Moscoso Jr, Walter E
11121 W Meinecke Ave, #8
Wauwatosa WI 53226

IM
Nagelhout, David A
1264 Kavanaugh Pl
Wauwatosa WI 53213

N IM PN*
Nausieda, Paul A
2025 East Newport Ave
Milwaukee WI 53211

ORS GS
Nord, Stephen L
6141 N Santa Monica
Whitefish Bay WI 53217

Otterson, Mary F
1930 West Birch Ct
Milwaukee WI 53209

Prein, Thomas E
1128 Kavanough Pl
Wauwatosa WI 53213

CD IM
Puchner, Thomas C
2300 N Mayfair Rd, #830
Wauwatosa WI 53226

Puig, Xiomara
9122 West Dixon St, #204
Milwaukee WI 53214

Purvis, Kathy J
1314 South 97th St
West Allis WI 53214

PM*
Reddy, Nanjappareddy M
1000 N 92nd St
Milwaukee WI 53226

FP
Redlin, Kenneth C
2319 East Euclid Ave
Milwaukee WI 53207

EM
Robinson, Jonathan
201 North Westfield
Madison WI 53717

DR R*
Rose, Quentin F
3481 North Lake Dr
Milwaukee WI 53211

Sandberg, James W
9131 West Dixon St, #7
Milwaukee WI 53214

continued

MILWAUKEE *continued*

IM* CD
Schuchard, Gregory H
2014 Forest St
Wauwatosa WI 53213

AN
Sheth, Pravin C
9611 W Meadow Park Dr
Hales Corners WI 53130

PM
Siliunas, Mindas V
8330 North 46th St, #101
Milwaukee WI 53233

FP
Small, Maureen D
2665 N Pierce St
Milwaukee WI 53212

Sullivan, Lawrence
2919 North 50th St
Milwaukee WI 53210

EM
Sutphen, Sussan K
2528 W Highland Blvd
Milwaukee WI 53233

Tomlinson, Craig P
8325 Portland Ave
Milwaukee WI 53226

FP
Trevino, Maria T
1834 West Wisconsin
Milwaukee WI 53233

FP
Trevino, Rodolfo N
1834 West Wisconsin
Milwaukee WI 53233

Twelmeyer, John M
1174 Pilgrim Parkway
Elm Grove WI 53122

FP
Velazquez, Arturo
5408 North 56th St
Milwaukee WI 53218

IM GS
Wartgow, Rick R
3939 N Murray Ave, #104
Milwaukee WI 53211

EM*
Waters, Victor O
1234 N 122nd St
Wauwatosa WI 53226

EM IM*
Whitcomb, John E
2900 W Oklahoma Ave
Milwaukee WI 53215

TR PD*
Wolfson, Sorrell L
2323 North Lake Dr
Milwaukee WI 53211

N
Wooten, Marvin R
2015 E Newport Ave
Milwaukee WI 53211

ONEIDA-VILAS

FP*
Robins, E Lanny
Eagle River WI 54521

OUTAGAMIE

FP
Quayle, James M
2917 North Drew St
Appleton WI 54911

PIERCE-ST CROIX

IM
Osterbauer, Joseph J
POB 68
New Richmond WI 54017

RACINE

OBG PD
Campbell, Mary I
5625 Washington Ave
Racine WI 53406

ROCK

IM*
Austin, John A
1200 Home Park Ave
Janesville WI 53545

IM
Baker, Charles S
202 Jefferson Ave
Janesville WI 53545

N PN*
Berentsen, Thomas R
580 N Washington St
Janesville WI 53545

D*
Boardman, Charles R
1905 Huebbe Parkway
Beloit WI 53511

PD*
Bostian, K Eugene
580 N Washington St
Janesville WI 53545

N PN*
Brugger, Andrew M
580 N Washington St
Janesville WI 53545

IM*
Deeds, Ernest C
580 N Washington St
Janesville WI 53545

OTO GS
Ellison, Warren R
580 N Washington St
Janesville WI 53545

PD*
Fossum, Jane E
1905 Huebbe Parkway
Beloit WI 53511

IM*
Gruhn, Stanley W
580 N Washington St
Janesville WI 53545

IM* RHU
Maciolek, Steven P
580 N Washington St
Janesville WI 53545

OTO* HNS
Mundy, John C
580 N Washington St
Janesville WI 53545

IM
Odette, William G
5 West Rollin
Edgerton WI 53534

D*
Pearson, Bruce R
580 N Washington St
Janesville WI 53545

OBG*
Vogel, James G
580 N Washington St
Janesville WI 53545

WAUKESHA

PS*
Feinberg, Lilla Breyer
1053 Lake Waterville
Oconomowoc WI 53066

IM
Gundersen II, Gunnar
2612 N Maryland, #107
Milwaukee WI 53211

IM*
Hennessy Jr, Donald J
W180 N7950 Town Hall Rd
Menomonee Falls WI 53051

FP*
Koewler, Thomas J
225 Eagle Lake Ave
Mukwonago WI 53149

EM IM*
Saperstein, Henry I
7370 North Seneca Rd
Fox Point WI 53217

AN
Woo, Sung-Kyun
1840 W Woodbury Lane
Glendale WI 53209

WOOD

Allen, Jon W
1700 N Apple Ave, #1N
Marshfield WI 54449

Elmeer, David C
422 Bluebird Ln
Marshfield WI 54449

FP*
Fontannini, Steven M (DO)
510 Marathon
Marshfield WI 54449

PS*
Hacker, Louis C
1000 North Oak Ave
Marshfield WI 54449

DR R*
Herbert, Timothy G
2300 Mann St
Marshfield WI 54449

ORS
Johnson, James A
420 Dewey St
POB 1265
Wisconsin Rapids WI 54494

N* EM
Karanjia, Percy N
1000 North Oak Ave
Marshfield WI 54449

P CHP
Kumaraperu, Indrani L
1126 Onstad
Marshfield WI 54449

DR IM*
Manor, William F
1000 North Oak Ave
Marshfield WI 54449

OPH
Miller, Kevin B
500 Dewey St
POB 309
Wisconsin Rapids WI 54494

continued

County society transfers

DANE
(from Marathon)
Jarzemsky, Daniel R
100 E North St
De Forest WI 53532

MARATHON
(from Price-Taylor)
Cameron, Vinoo
101 W Gibson Ave
Medford WI 54451

MILWAUKEE
(from Dane)
Kieser, Randall J
1614 E Newton Ave
Shorewood WI 53211

RACINE
(from Ozaukee)
Paquette, Camille A
1120 Main St
Union Grove WI 53182

WAUKESHA
(from Milwaukee)
Cooper-Young, Helen M
515 W Moreland Blvd
Waukesha WI 53186

WOOD
(from Oneida-Vilas)
Wood, Michael T
1000 North Oak Ave
Marshfield WI 54449■

Members! Are your Membership Records current?

The ***1985 Membership Directory*** will contain a list of all members of record at May 31 as compiled by the Membership Department. The following information will be included:

County Medical Society _____

Up to 3 specialties recognized by the AMA, by code (see opposite page)

1	2	3
PRIMARY	SECONDARY	SECONDARY

Up to three Board certified specialties or subspecialties, by code (see opposite page)

4	5	6
PRIMARY	SECONDARY	SECONDARY

Phone number (if desired) ( )

Name _____

Address _____

_____

City _____ State _____ Zip _____

Members are encouraged to review the information here and on the opposite page in preparation of completing the ***Membership Records Verification Form*** which will be sent to all members of record at May 31. Watch your mail for this ***Verification Form;*** it will be the only one sent.

Type of practice

- ☐ Resident—First Year
- ☐ Resident—All Other Years
- ☐ Direct Patient Care
- ☐ Administration
- ☐ Medical Teaching
- ☐ Student
- ☐ Temporarily not in practice
- ☐ Not active for other reasons
- ☐ Medical Research
- ☐ Other Patient Care
- ☐ Other Non-Patient Care
- ☐ Inactive
- ☐ No Classification
- ☐ Retired
- ☐ Semi-Retired
- ☐ Disabled

Identification of specialties, secondary or subspecialties, and Board certification, as recognized by the AMA

Primary and secondary specialties recognized by the AMA appear below in the column of boxes numbered 1, 2 3 (limited to no more than three specialties); Board certifications recognized by the AMA* appear below in the column of boxes numbered 4, 5, 6 (limited to no more than three certifications). Note that only Board certifications will be permitted from the boards of the American Board of Medical Specialists* which are recognized by the AMA. See sample form on opposite page for information to be included in the 1985 Membership Directory to be published in the July issue of the Wisconsin Medical Journal.

AMA recognized specialties 1 2 3	Board certified specialties and subspecialties* 4 5 6		
☐		A	Allergy
☐		ABS	Abdominal Surgery
☐		ADL	Adolescent Medicine
☐	☐	AI	Allergy and Immunology
☐	☐	AM	Aerospace Medicine
☐	☐	AN	Anesthesiology
	☐	AP	Anatomic Pathology
☐		BE	Broncho-esophagology
☐	☐	BLB	Bloodbanking
	☐	CCM	Critical Care Medicine
☐	☐	CD	Cardiovascular Diseases
☐		CDS	Cardiovascular Surgery
☐	☐	CHN	Child Neurology
☐	☐	CLP	Clinical Pathology
	☐	CP	Chemical Pathology
☐	☐	CRS	Colon and Rectal Surgery
☐	☐	D	Dermatology
	☐	DI	Dermatological Immunology
☐		DIA	Diabetes
	☐	DLI	Diagnostic Laboratory Immunology
☐	☐	DMP	Dermatopathology
☐	☐	DR	Diagnostic Radiology
☐	☐	EM	Emergency Medicine
☐		END	Endocrinology
	☐	END	Endocrinology and Metabolism
☐	☐	FOP	Forensic Pathology
☐	☐	FP	Family Practice
☐	☐	GE	Gastroenterology
☐		GER	Geriatrics
	☐	GON	Gynecologic Oncology
☐		GP	General Practice
☐		GPM	General Preventive Medicine
	☐	GPM	Public Health and General Preventive Medicine
☐	☐	GS	General Surgery
	☐	GVS	General Vascular Surgery
☐		GYN	Gynecology
☐	☐	HEM	Hematology
☐		HNS	Head and Neck Surgery
☐		HS	Hand Surgery
☐		HYP	Hypnosis
☐	☐	ID	Infectious Diseases
☐		IG	Immunology
☐	☐	IM	Internal Medicine
	☐	IP	Immunopathology
☐		LAR	Laryngology
☐		LM	Legal Medicine
	☐	MFM	Maternal and Fetal Medicine
☐		MFS	Maxillofacial Surgery
	☐	MMB	Medical Microbiology
	☐	MON	Medical Oncology
☐	☐	N	Neurology
☐	☐	NA	Neuropathology
☐		ND	Neoplastic Diseases
☐	☐	NEP	Nephrology
☐	☐	NM	Nuclear Medicine
☐	☐	NPM	Neonatal-perinatal Medicine
☐	☐	NR	Nuclear Radiology
	☐	NRP	Radioisotopic Pathology and Nuclear Radiology
☐	☐	NS	Neurological Surgery
☐		NTR	Nutrition
☐	☐	OBG	Obstetrics and Gynecology
☐		OBS	Obstetrics
☐	☐	OM	Occupational Medicine
☐		ON	Oncology
☐	☐	OPH	Ophthalmology
☐	☐	ORS	Orthopedic Surgery
☐		OS	Other; *ie*, physician designated a specialty other than appearing here
☐		OT	Otology
☐	☐	OTO	Otorhinolaryngology
☐	☐	P	Psychiatry
☐		PA	Clinical Pharmacology
☐	☐	PD	Pediatrics
☐		PDA	Pediatric Allergy
☐	☐	PDC	Pediatric Cardiology
☐	☐	PDE	Pediatric Endocrinology
☐		PDR	Pediatric Radiology
☐	☐	PDS	Pediatric Surgery
☐		PH	Public Health
☐	☐	PHO	Pediatric Hematology-Oncology
☐	☐	PM	Physical Medicine and Rehabilitation
☐	☐	PNP	Pediatric Nephrology
☐	☐	PS	Plastic Surgery
☐		PTH	Pathology
	☐	PTH	Anatomic and Clinical Pathology
☐	☐	PUD	Pulmonary Diseases
☐		PYA	Psychoanalysis
☐		PYM	Psychosomatic Medicine
☐		R	Radiology
	☐	RE	Reproductive Endocrinology
☐		RHI	Rhinology
☐	☐	RHU	Rheumatology
☐		RIP	Radioisotopic Radiology
	☐	RP	Radioisotopic Pathology
☐	☐	TR	Therapeutic Radiology
☐		TRS	Traumatic Surgery
☐	☐	TS	Thoracic Surgery
	☐	U	Urology
☐		U	Urological Surgery

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- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Pathology
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- ☐ Psychiatry and Neurology
- ☐ Radiology
- ☐ Surgery
- ☐ Thoracic Surgery
- ☐ Urology

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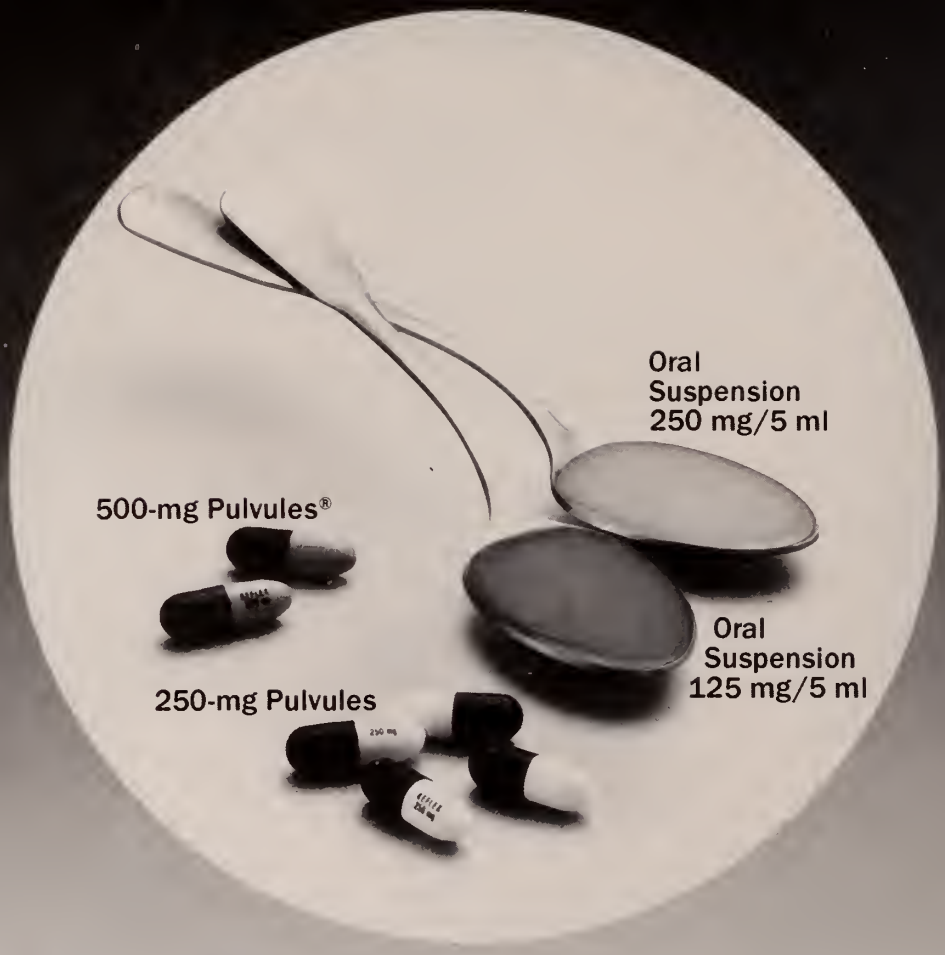

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John Kraft, MD, recently started his medical practice with the Grafton Clinic. A graduate of the Medical College of Wisconsin, Doctor Kraft previously had been associated with the Elmbrook Hospital in the Department of Emergency Medicine and had a general medical practice in the Milwaukee area.

Howard Dubner, MD, Shorewood, has been appointed the first medical director of St Joseph's Hospital Oncology Center, Milwaukee. Doctor Dubner joined the St Joseph's Hospital medical staff in 1974. He is a 1969 graduate of the University of Illinois Medical School and served his internship and residency at the University of Cincinnati from 1969 to 1972 and a fellowship from the University of Wisconsin, Madison, from 1972 to 1974.

M Scott Harris, MD, Mequon, has been appointed assistant professor of medicine at the Medical College of Wisconsin, Milwaukee. He is based at the Veterans Administration Medical Center, Wood, and the Milwaukee Regional Medical Center. Doctor Harris graduated from Harvard Medical School and served his internship and residency at the Johns Hopkins Hospital and at the Hospital of the University of Pennsylvania in Philadelphia, PA.

Terry L Hankey, MD,* Wausau, recently was appointed to the Committee on Research of the American Academy of Family Physicians. The Committee oversees and coordinates the Academy research programs.

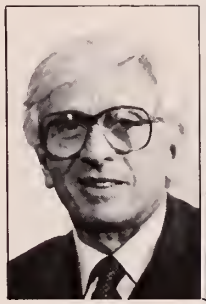
John R Kludt, MD,* Eau Claire, is the new program director of the Eau Claire Family Practice Residency Program. He succeeds Patrick W Connerly, MD.* He graduated from the University of Washington School of Medicine and completed his family practice residency at the Weld County General Hospital in Greeley, CO. He previously was assistant director at the Family Practice Residency Training Program for North Colorado Medical Center in Greeley.

Philip J Taugher, MD,* Franklin, has been named to the Board of Directors of West Allis Memorial Hospital. A member of the West Allis Memorial Hospital medical staff since 1971, Doctor Taugher served as chief-of-staff from 1983 through 1984 and also was head of the Section of Ophthalmology from 1978 through 1980. He is a graduate of Marquette University School of Medicine.

Susan F Behrens, MD,* Beloit, recently became a fellow of the American College of Surgeons. Doctor Behrens graduated from the University of Wisconsin Medical School, Madison, and is currently a member of the medical staff at Beloit Memorial Hospital. In 1984 she was elected chairman of the Wisconsin Medical Examining Board. In March 1983, Doctor Behrens was the first woman to become a member of the Wisconsin Surgical Society.

Parnell Donahue, MD, is the new medical director of the Grafton Clinic. Doctor Donahue, a graduate from Marquette University School of Medicine, also is associated with the Sports Medicine and Knee Surgery Center and the Good Samaritan Sports Medicine Institute in Milwaukee. Doctor Donahue in addition to his duties as the medical director of the Clinic, also will practice adolescent medicine and sports medicine. He previously was in medical practice in Hartford.

Martin Vick, MD, Ashland, recently joined the Carol A Blum, MD,* SC, anesthesiology practice. Originally from Minneapolis, Doctor Vick graduated from the University of Minnesota Medical School and completed his residency at Abbott-Northwestern Hospital and at the University of Minnesota Hospitals in Minneapolis.



Doctor Goldberg

Doctor Rice

Burton Goldberg, MD, Madison, who joined the University of Wisconsin faculty in January, has been named chairman of the UW Medical School's department of pathology and laboratory medicine. Doctor Goldberg previously served as professor of pathology at the New York University School of Medicine, New York City. A 1950 graduate of Northwestern University Medical School, Chicago, Doctor Goldberg served his internship at Cincinnati General Hospital, Ohio, and completed his residency at Boston City Hospital's Mallory Institute.

Richard Rice, MD, recently became associated with the medical staff of the Middleton Clinic. Doctor Rice graduated from the Iowa Medical School, Iowa City, and served his internship in Des Moines before entering the United States Air Force. His residency training was completed at the UW Medical School, Madison. Prior to joining the Middleton Clinic, he had been in private practice in Freeport, Ill.

CES Foundation

of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of March 1985.

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Marcella Herfel
Doug and Dee Miller
Mavis and Reese Minor
Joan Pyre
Herbert Sandmire, MD

James L Sebastian, MD, Wauwatosa, recently was appointed assistant professor of medicine at the Medical College of Wisconsin. Doctor Sebastian graduated from Indiana University School of Medicine and served his residency at the Medical College of Wisconsin. He is on the medical staff at the Veterans Administration Medical Center.

Paul R Meier, MD, Marshfield, has joined the medical staff of the Marshfield Clinic. Doctor Meier graduated from Loma Linda University School of Medicine and completed his residency at the University of California-San Diego. He also completed his fellowship at the University of Colorado Health Sciences Center in Denver. Doctor Meier was a member of the perinatal staff of the Kaiser Permanente Hospital, San Diego, and also was an assistant professor of obstetrics and gynecology at the University of Colorado School of Medicine.

James F Guhl, MD,* Elm Grove, recently was elected secretary of the International Arthroscopy Association. He is immediate past president of the Arthroscopy Association of North America.

R Arthur Gindin, MD, Monroe, has joined the medical staff of the Monroe Clinic. Doctor Gindin was in private practice in Portsmouth, Ohio, before coming to the Clinic. He graduated from the Medical College of Virginia and served his internship at the University of Oklahoma Hospital, Oklahoma City. His residency was completed at USPHS Hospital, Staten Island, NY, followed by a fellowship at the Montreal Neurosurgical Institute, Montreal, Canada. He was on the faculty at the Medical College of Georgia in Augusta and had been chief of neurosurgery at the Veteran's Administration Hospital in Augusta. ■

Midelfort Clinic, Eau Claire, recently appointed Robert L Downs as executive director. Mr Downs succeeds James R Jepson, administrator since 1979, who has accepted a position in Florida. Mr Downs is a graduate of Notre Dame University and also has a master's degree in Health Care Administration from the University of Minnesota. For the past six years, he has been administrator of The Medical Associates Clinic in Dubuque, Iowa. Mr Downs is a member of the Medical Group Management Association and a fellow in the American College of Medical Group Administrators.

Group Health Cooperative, a Dane County health maintenance organization, has selected John P Hansen, MD* as its new medical director effective in July 1985. Doctor Hansen currently is associate professor, Department of Family Medicine and Practice, and director, Madison Residency Department of Family Medicine and Practice at the University of Wisconsin. He graduated from the University of Wisconsin Medical School, Madison, and also received a Master of Science degree from the School of Public Health, University of North Carolina.

Marshfield Clinic has named Robert J De Vita associate director of its prepaid plans. Mr DeVita was executive director of Southern Health Plan, the Blue Cross and Blue Shield health maintenance organization in Memphis, Tenn, before joining the Clinic. Previously he was medical practice administrator for the University of Tennessee College of Medicine, Memphis; medical services administrator for Eastern Virginia Medical Authority in Norfolk, Va, and business manager for the department of anesthesiology at the Medical College of Wisconsin in Milwaukee.

Neillsville Clinic recently announced the following physicians to head its medical staff for 1985. They are MDs N Neelagaru,* president; Bahri Gungor,* secretary; and Vangala Reddy* as treasurer. Other members of the medical staff are MDs N R Capati,* R V Reddy,* Ana Capati, and Rupa Chinnamaneni.

Calumet Memorial Hospital, Chilton, has announced the following physicians to head its medical staff. They are Alvin C Theiler, MD*, president; Gene A Tipler, MD*, vice-president; William E Hannon, MD,* secretary-treasurer; and Randy T Theiler, MD, immediate past president.■

Clues!

As important to a diagnosing physician as they were to Sherlock Holmes. Without clues, in the diagnosis of thoracic complications, the physician may face unnecessary delays and the patient unnecessary hospitalization and surgery.

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CLARK: At the March meeting of the Clark County Medical Society, Vangala J Reddy, MD,* Neillsville, was elected president for a two-year term. Rupa Chennamaneni, MD* was chosen secretary. Guest speaker at the meeting was Michael E Ryan, MD* from the Marshfield Clinic.

State Division of Health

Statewide pneumoconosis radiologic consultation program begins June 1

Occupational disease reporting has been part of Wisconsin statutes for many years. Under-reporting of disease is widespread, due to the difficulty of diagnosis and physician unfamiliarity with occupational disease. Much of the difficulty in diagnosis of pneumoconosis arises from the unfamiliarity of physicians (other than specialty-trained x-ray interpreters) with the international pneumoconosis classification which allows a consistent and schematic interpretation to classify radiologic evidence of pneumoconosis. The State, in recognition of these difficulties and the paucity of NIOSH-trained physicians in the state, is implementing a radiologic consultation program. An NIOSH-trained B-reader will provide an ILO pneumoconosis interpretation and classification of submitted x-rays, in accordance with NIOSH standards.

In June the State Division of Health will begin accepting submitted x-ray films. Physicians who have patients with an unusual pleural or parenchymal radiograph and a history of dust exposure are encouraged to participate.

To participate a physician need only send the patient's chest radiograph, accompanied by a Physician's X-ray Submission Sheet (a short dust exposure history form provided by the State) to the Division of Health.

The x-ray will be classified and returned to the sender with a full written report of the findings. *This program will not replace or function as an employee periodic examination program, nor is it a replacement for final physician diagnosis.*

All information will remain confidential as part of the patient's medical records. Only information in tabular aggregate form will be released as part of periodic project summaries. Physicians who wish to participate in the pilot program or wish more information may contact either Henry A Anderson, MD (a member of the State Medical Society's Committee on Environmental and Occupational Health and Chief, Section of Environmental and Chronic Disease Epidemiology, State Division of Health) or Barbara Pennington, Project Coordinator in the State Division of Health at (608) 266-7338. ■

MONROE: The January meeting of the Monroe County Medical Society was held in Tomah. Guest speaker Thomas N Roberts, MD, La Crosse, spoke on "Reyes Syndrome." MDs Janet S Chestnut* and Michael J Saunders* were elected to membership.

SAUK: At the February meeting of the Sauk County Medical Society, ten members were present. Robert James Koontz, MD,* Reedsburg, was the guest speaker.

SAUK: The March meeting of the Sauk County Medical Society was held in Spring Green. Ron Henrichs, Director of Membership and Communications of SMS, discussed the recent survey of physicians in the State of Wisconsin.

WINNEBAGO: Twenty-four members and one guest were present at the April meeting of the Winnebago County Medical Society. Guest speaker for the meeting was Robert A Bonebrake, MD* of Madison. Doctor Bonebrake spoke on "Diagnosis and Treatment of Osteoarthritis."

WINNEBAGO: Thirty-eight members and two guests were present at the March meeting of the Winnebago County Medical Society. Merton D Finkler, Professor of Economics at Lawrence University, Appleton, spoke on "Regulation and Competition in Health Care." New physicians admitted to Society membership are Gizell M Rosetti,* Neenah; and Curtis D Radford,* Winneconne. ■

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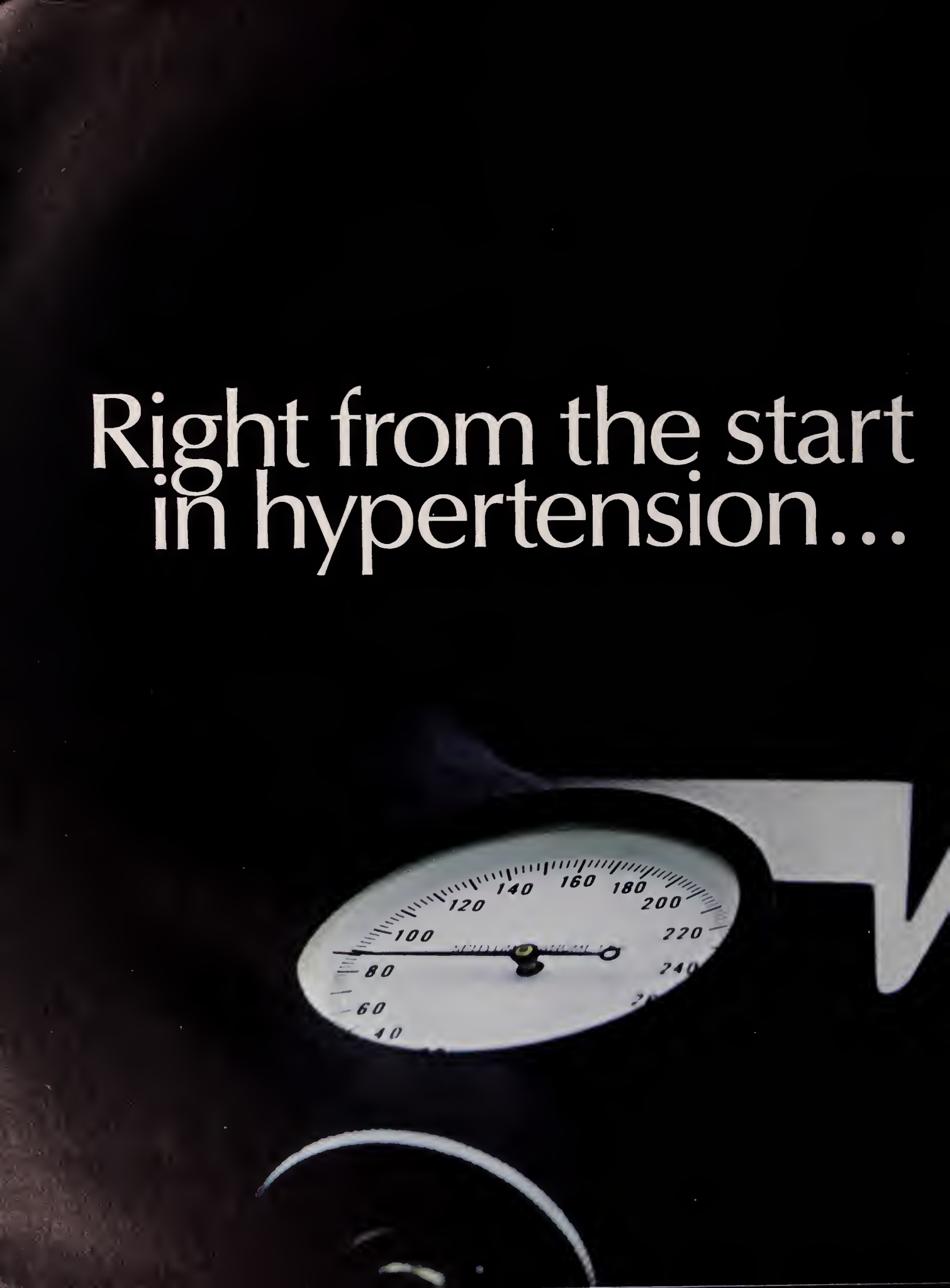

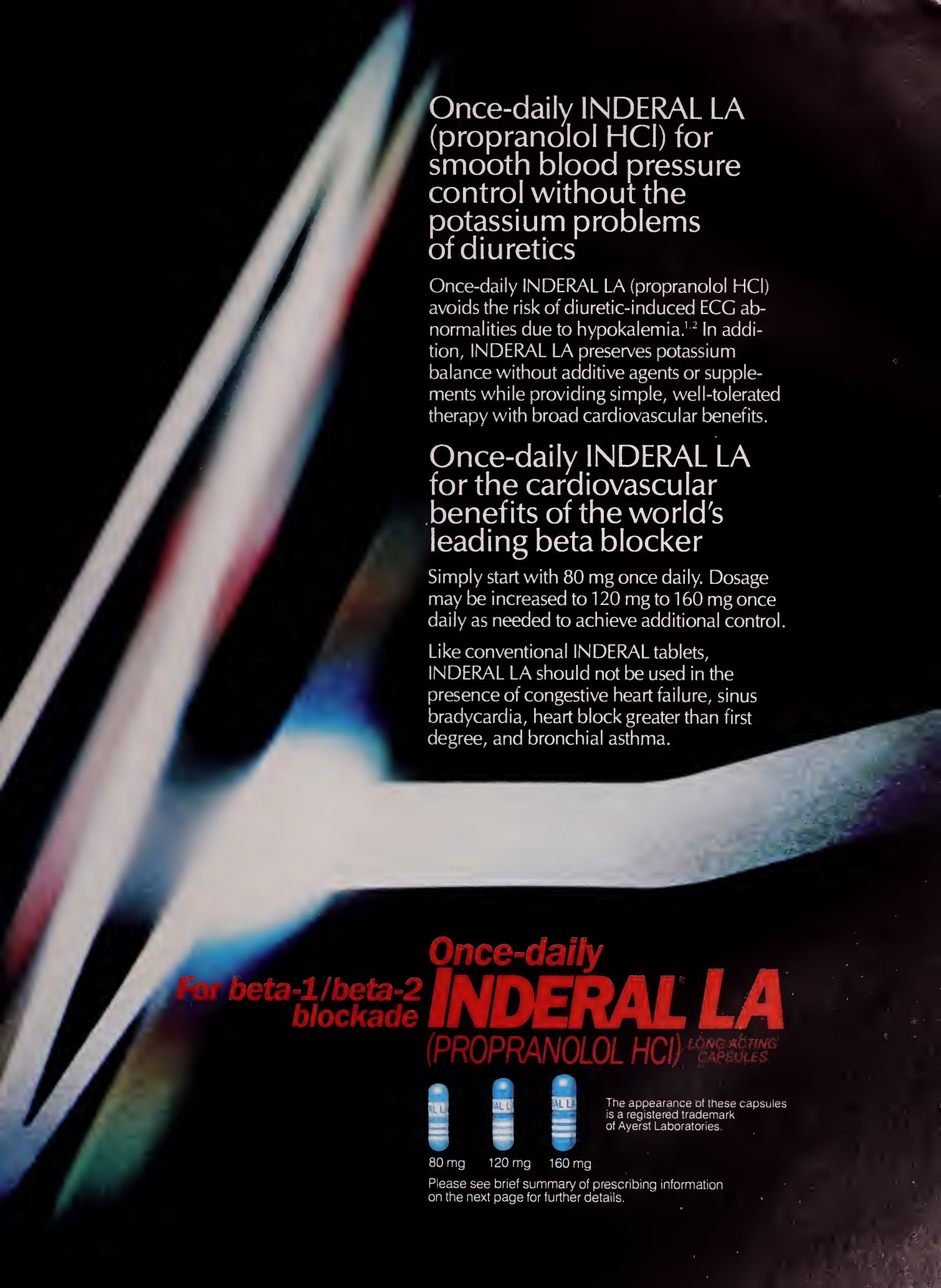

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Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

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For beta-1/beta-2 blockade

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80 mg 120 mg 160 mg

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Please see brief summary of prescribing information on the next page for further details.

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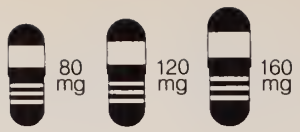

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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Some basic rules to follow when writing to your legislator

Legislators do indeed listen to the sentiments expressed by their constituents. But, in order for them to listen, the constituent must speak—and speak to the issue. While the letter you write to your legislator may not change the course of history, it can have an impact, particularly if you observe some fundamental guidelines.

Identify yourself

Your letter will be given more serious consideration if it is typewritten on your personal or professional letterhead. Your name and address, clearly indicated, will invite a response.

Identify your reason for writing

Specify the issue which has prompted your letter in your opening sentence. If you are writing with regard to a particular piece of legislation, refer to the bill by title and number, if possible.

State your case

Your own personal experience is your best supporting evidence. Explain how the issue would affect you, your profession, or what effect it could have on your community. Try to be specific and brief. Back your position with reliable facts and figures, and clearly state whether you are for or against the bill. You may think that the facts speak for themselves, but the legislator may be less familiar with the subject.

Timing is essential

The best time to let your legislator know your views is generally while a bill is still in committee. If he or she has not already taken a position, constituent sentiments will be of concern and may serve to influence an ultimate decision. If, on the other hand, your representative has already formed an opinion, your letter will let him or her know that you support or oppose that stand.

Concentrate your efforts

In addition to your own legislators, you may wish to write the chairperson or members of a committee holding hearings on legislation in which you are interested. However, remember that you have more influence with your own legislators, and efforts to contact others can prove time-consuming and are not likely to net much result.

Don't write a form letter

Phrasing which makes your letter read as though it is part of an organized pressure effort should be avoided. Form letters generally produce little or no impact.

Request a reply

Ask that your legislator respond to your letter with a statement of his or her position on the issue or legislation. As a constituent, it is your right to request such information.

Remember your manners

Do not underestimate the power of a simple 'thank you!' If your legislator casts a vote of which you approve, write a followup letter in support of the action. If, on the other hand, you disapprove of the vote, don't hesitate to let them know that too.

Don't demand the impossible

In fact *don't demand anything!* Don't issue threats or ultimatums. Taking any stance which makes you sound unreasonable will not further your case. ■

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Joseph D Bonan, MD, 70, Wauwatosa, died Feb 12, 1985 in Wauwatosa. Born Jan 16, 1915 in Rochester, New York, Doctor Bonan graduated from Marquette University School of Medicine in 1942 and served his internship at Misericordia Hospital. Doctor Bonan was a member of the medical staff of Elmbrook Memorial and St Anthony's hospitals and served as chief-of-staff at St Anthony's Hospital in 1973. He retired from medical practice in 1982. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are two sons, J Daniel and Robert J; and one daughter, Jean.

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Gerard J Biedlingmaier, MD, 56, Wauwatosa, died Feb 15, 1985 in Wauwatosa. Born July 10, 1929 in Scranton, Pa, Doctor Biedlingmaier graduated from Jefferson Medical College of Philadelphia in 1954 and served his internship at Scranton State General Hospital. His residency was completed at Temple University Medical Center, Philadelphia, Pa. Doctor Biedlingmaier was on the medical staff of Trinity Memorial Hospital, Cudahy. He served in the United States Navy from 1955-57. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Mary, and five children.

Edwin P Bickler, MD, 87, Wauwatosa, died Mar 2, 1985 in Milwaukee. Born June 15, 1897 in Belgium, Wis, Doctor Bickler graduated from Marquette University School of Medicine, Milwaukee, and served his internship at St Mary's Hospital in Milwaukee. He also did postgraduate studies at the University of Pennsylvania. Doctor Bickler practiced in Milwaukee from 1925 until 1975. He also was a consulting physician for Briggs & Stratton Corp. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are three brothers, Emil, Belgium; William, Milwaukee; and Joseph of San Diego, Calif.

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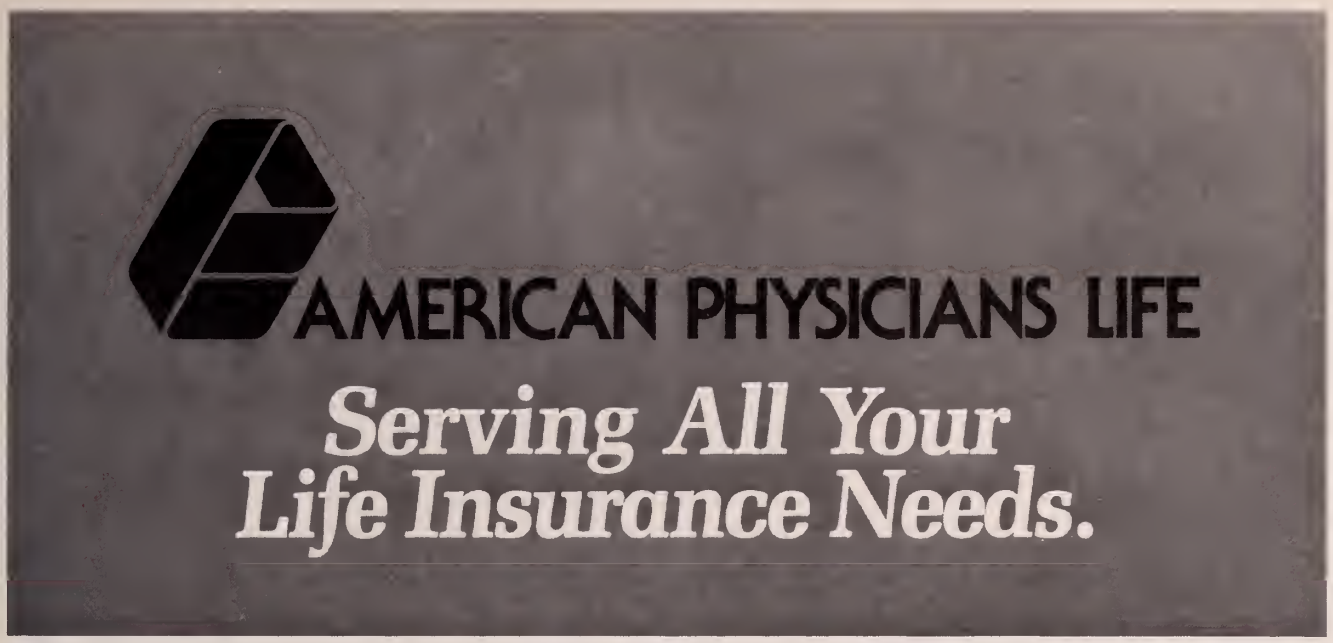
Stella I Burdette, MD, 86, Amery, died Mar 8, 1985 in Amery. Born Sept 10, 1898 in Ruskin, TN, Doctor Burdette graduated from the University of Wisconsin Medical School, Madison, in 1934. Her internship was served at Wisconsin General Hospital (now UW Hospital and Clinics), Madison, and she completed her residency at Pine Breese Sanitorium in Chattanooga, TN. Doctor Burdette practiced medicine in Elroy until 1950 when she moved to Balsam Lake. She retired in 1971. Surviving is her husband, Leo.

Richard W Farnsworth, MD, 82, Janesville died March 10, 1985 in Janesville. Born June 14, 1902 in Janesville, Doctor Farnsworth graduated from Harvard University Medical School and served his internship at Peter Bent Brigham Hospital in Massachusetts. Doctor Farnsworth served in the United States Army Medical Corps from 1942-1947 during World War II. He practiced in Janesville for 38 years until his retirement in 1978. He was a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Ella; a daughter, Susan Heusler, St Charles, Mo; a son, George, Milwaukee; two stepsons, Samuel Richards, Janesville, and Raymond Richards, Kimberly; and a stepdaughter, Linda Bellman of Madison.■



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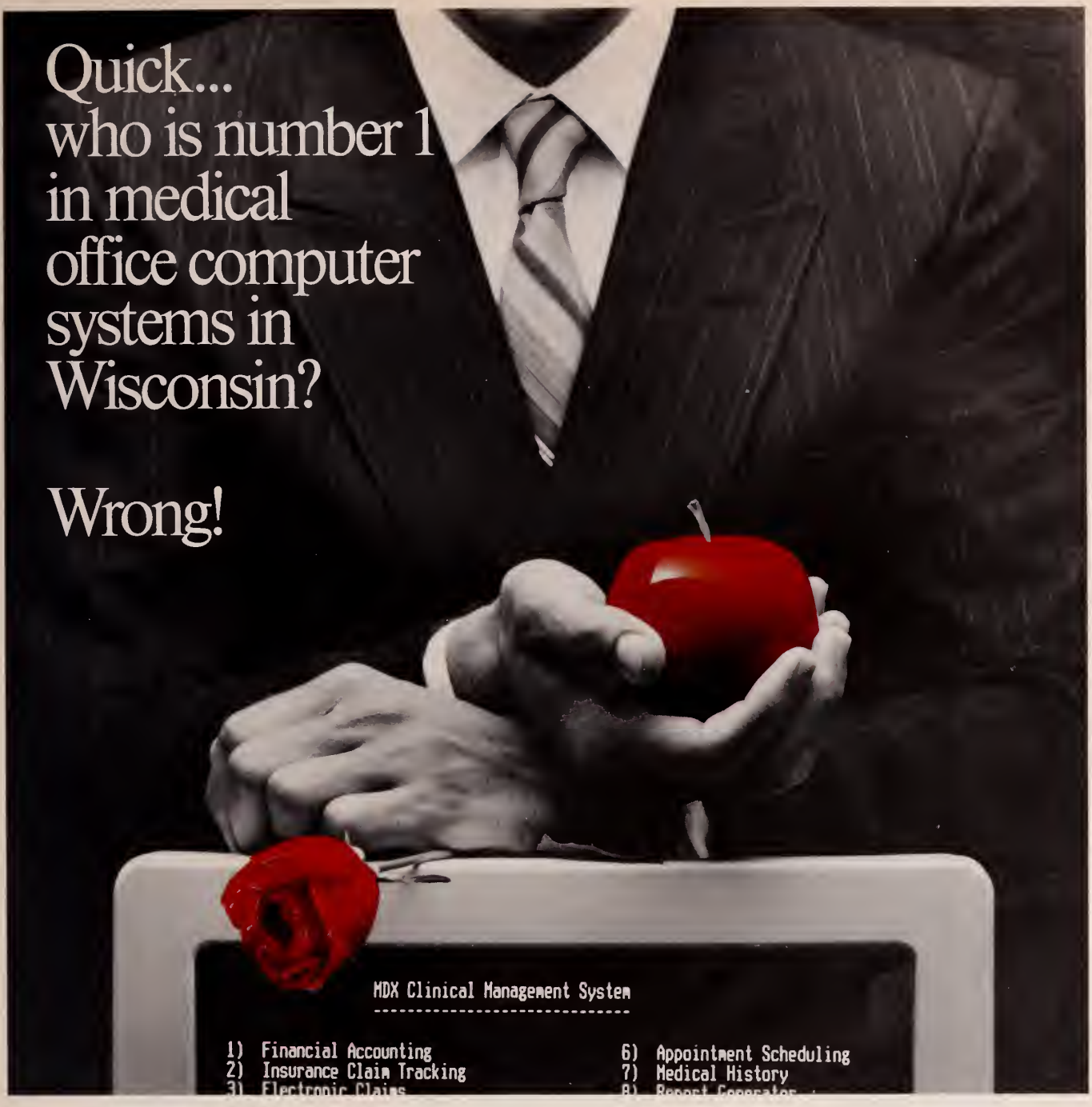

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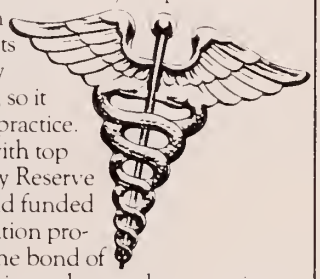

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US Air Force Medical Corps Currently has opportunities for specialty physicians. Excellent benefits and attractive practice settings worldwide, ranging from small clinics to 1,000-bed medical centers. Positions currently available include Family Practice, Internal Medicine, Cardiology, Psychiatry, General and Orthopedic Surgery, Otorhinolaryngology, as well as Aerospace Medicine. For qualifications and more information write to 310 W Wisconsin Ave, Suite 380, Milwaukee WI 53202-2278, Attn: Capt Sealey or call 1-800/242-USAF. 5-7/85

Internist/Family Practice: Board Certified or board eligible. Established 50-doctor multispecialty group practice located in the Milwaukee, Wisconsin metropolitan area. Expanding practice needs 2 internists and a family practitioner. Competitive salary and excellent fringe benefits. Address inquiries and curriculum vitae to Medical Director, PO Box 427, Menomonee Falls, Wisconsin 53051. p4-5/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

Family Practitioner. The Racine Medical Clinic, a progressive cluster corporation of 31-physicians is currently seeking a family practitioner. Full benefits, unlimited earnings, and a full and exciting practice are offered. Please contact Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 4tfn/85

PHYSICIANS WANTED
Full or part-time PHYSICIANS WANTED for emergency room work throughout Wisconsin. National Emergency Services offers excellent income, paid malpractice insurance, and flexible scheduling. If you're interested in exploring opportunities with NES and you would like additional information, call James Lucas at 1-800/537-3355. 5-6/85

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone: 608/263-4095 7/84;6/85

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 4-9/85

The Racine Medical Clinic, a progressive cluster corporation of 31 physicians is currently seeking an Obstetrician/Gynecologist physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 12tfn/84

Wisconsin-BC/BE Pediatrician to assume an established position of a pediatrician leaving. Join a three-man pediatric department. Call or write: David L Lawrence, MD, 92 E Division St, Fond du Lac, WI 54935; ph 414/921-0560. p3-8/85

MESA is on the MOVE
in
Northern Illinois, Wisconsin
and the Chicagoland Area

We are seeking Board Certified/eligible and Emergency Trained Physicians to join our growing organization.

- Compensation/Benefit Packages are highly competitive with administrative and educational support services.
- Management and Staff positions for Emergency Departments and Ambulatory Care Centers.
- Excellent communication skills and the desire to excel in Emergency Medicine is a necessity.

MESA *Medical Emergency Service Associates, SC* over 20 years of excellence in Emergency Medicine.

Contact: Ms Debbie Carsky, Director of Recruitment, 312/459-7304 (collect) or write to 15 South McHenry Road, Buffalo Grove, IL 60090. p5/85

PHYSICIANS EXCHANGE

continued

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Immediate opportunities for qualified physicians who possess excellent clinical and communication skills to join long-standing group of Emergency Physicians. Positions available in a popular Wisconsin area bordering Illinois. If interested, send resume to Barbara Wilczynski, Medical Emergency, Service Associates (MESA), SC, 15 S McHenry Road, Suite 2, Buffalo Grove, IL 60090 or call collect 312/459-7304. 6tfn/83

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Family Physicians, Ophthalmologist, Orthopedist needed to join 30 physicians of the Olmsted Medical Group of Rochester. Opportunities available in main office and satellites. Exceptional salary and benefit package provided in a choice professional and cultural community. Contact James E Hartfield, MD, Medical Director, 210 Ninth Street SE, Rochester, MN 55903; ph 507/288-3443. 5-7/85

MEDICAL FACILITIES

Family Practice for sale in Milwaukee. Ideal starter or satellite office. Excellent patient goodwill. Fully equipped and furnished three examining rooms, waiting room, and office. Approximately 900 sq ft. Contact Greg Rodenbeck, DDS, 1200 E Oklahoma Ave, Milwaukee, Wis 53207; 414/481-8111. g10tfn/84

Family Practice office available in south central Wisconsin. Contact Dept 555 in care of the Journal. 4-5/85

For Sale. Like-new medical office furniture for sale—desks, chairs, examining tables, typewriters, file cabinets, x-ray viewers, computer (Victor 9000), and miscellaneous items. Phone 715/369-1261. p4-5/85

Medical equipment, examining tables, treatment tables, instrument cabinets, etc. Available in June at no cost. Retiring. Phone 414/284-2676. 5/85

Medical practice or equipment for sale in Milwaukee. Completely equipped, modern office with a modern x-ray machine. I am retiring. Please call 414/272-0250 or 414/962-9382 for an appointment. 5/85

Beaver Dam, Wisconsin. New medical office 1250 or 2500 sq ft office space available. Excellent opportunity for Dermatology or Allergy practice. Call 414/887-8887 or write PO Box 678, Beaver Dam, WI 53916. 5-8/85

Brick medical office building in very good condition. Seven examining rooms, lab and x-ray. Well-equipped. Ideal for one to four doctors. Parking. Northwest Milwaukee. Under $80,000. Contact Pete Picciolo. Re/Max sw inc. Ph 414/784-9220. 5/85

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Enjoy a vacation, reunion, or mini-conference at Cedarwood on the beautiful, wooded grounds of Green Lake Conference Center. This newly constructed seven bedroom lodge can also be rented by week as separate three, four, or five bedroom units. Tennis courts, large indoor pool, nature trails, challenging golf course, miles of private roads for biking are available on the grounds. Pier and boat launch available for Cedarwood guests. Call 414/294-3894 for weekly reservations or write to Cedarwood, Green Lake Conference Center, Green Lake, WI 54941. Also available for winter outings—over 20-miles of groomed ski trails. 5/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

JUNE 3–8, 1985: *18th Annual Postgraduate Course in Gynecological Pathology, Endocrinology, and Maternal-Fetal Medicine,* presented by the Department of Gynecology and Obstetrics of the Medical College of Wisconsin. The course will be held at Olympia Resort, Oconomowoc. The six-day course includes an up-to-date review of endocrinology, maternal-fetal medicine, and cytogenetics in addition to a thorough resume of gynecologic pathology. Registration is limited. Course approved for 46 cognates, Formal Learning, by the American College of Obstetricians and Gynecologists and 46 credit hours, Category I, PRA/AMA. Eighty selected 35-mm slides will be available for purchase to all participants. Contact Richard F Mattingly, MD, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, WI 53226; tel 414/257-5560. p3-5/85

JUNE 12–15, 1985: *37th Annual Scientific Assembly of the Wisconsin Academy of Family Physicians,* Americana Resort Hotel, Lake Geneva, Wisconsin. Info: WAFP, 850 Elm Grove Road, Elm Grove, WI 53122; ph 414/784-3656. 12/84;1-5/85

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

JUNE 28, 1985: *Microcomputers in Medicine,* Milwaukee. A one-day computer seminar and exposition for health care professionals. Topics include choosing a system; office practice management, computer-aided diagnosis. Fee: $50 before May 15 includes admission, lunch, and reception. Info: Micros in Medicine, MCW Libraries, 8701 Watertown Plank Rd, Milwaukee, WI 53226; ph 414/257-8323. g3-4/85

JULY 17-18, 1985: *5th Annual Common Emergency Care Conference,* Sheraton Inn, Madison. AMA, AAFP, ACEP credit. Sponsored by University of Wisconsin Emergency Medical Services Program and Continuing Medical Education. Features workshops. Contact Sarah Aslakson, UW, CME, Room 465B, 610 Walnut St, Madison, Wis 53705; ph 608/263-2856. 5/85

For physicians, hospital administrators

Biomedical ethics conference
June 6-7, American Club, Kohler

Sponsored by State Medical Society of Wisconsin and Wisconsin Hospital Association

For further info contact SMS offices in Madison: Michelle Scoville

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Announces
A Seminar for Primary Care Physicians

"Inflammatory Bowel Disease — An Update"
With
Richard G. Farmer, M.D., F.A.C.P.
Dept. of Gastroenterology, Cleveland Clinic Hospital

Thursday, June 13, 1985
1:00 - 5:00 p.m.
Medical College of Wisconsin

For Registration or More Information call GMIC Hotline: 242-GMIC

JULY 18-20, 1985: Wisconsin Society of Obstetrics & Gynecology, Olympia Resort, Oconomowoc. g2-6/85

SEPTEMBER 6-8, 1985: Wisconsin Society of Anesthesiologists, American Club, Kohler. g5-8/85

SEPTEMBER 12-14, 1985: Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting—30th Anniversary, the Pioneer Inn, Oshkosh. Info: Wisconsin Society of Internal Medicine, 611 E Wells St, Milwaukee, Wis 53202; ph 414/276-6445. Contact: Sandra M Koehler, Executive Director. 5-8/85

SEPTEMBER 13-14, 1985: Wisconsin Neurosurgical Society, Sheraton, Racine. g5-8/85

SEPTEMBER 13-14, 1985: Wisconsin Surgical Society, Paper Valley Hotel & Conference Center, Appleton. g2-8/85

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1986-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the La Crosse Convention Center.

1986—April 17-19
1987—March 26-28
1988—April 28-30
1989—April 13-15
1990—April 26-28
1991—April 18-20
1992—April 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

SEPTEMBER 27-28, 1985: Wisconsin Neurological Society, Paper Valley Hotel & Conference Center, Appleton. g5-8/85

SEPTEMBER 28-29, 1985: Wisconsin Otolaryngological Society, Head and Neck Surgery. Heidel House, Green Lake. g5-8/85

OCTOBER 10-11, 1985: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. g5-9/85

OTHERS

JUNE 5-8, 1985 (Alaska): Alaska State Medical Association Annual Convention in Haines. Info: Alaska State Medical Association, 4107 Laurel St, Ste #1, Anchorage, Alaska 99508; ph 907/562-2662. g2-5/85

JUNE 22-23, 1985 (Minnesota): *Management of Common Psychiatric Problems in Primary Care,* Breezy Point Resort, Brainerd. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3-85

Wisconsin Specialty Society Meetings

- Wisconsin Academy of Family Physicians, June 12-15, 1985, Americana Resort, Lake Geneva
- Wisconsin Society of Obstetrics & Gynecology, July 18-20, 1985, Olympia Resort, Oconomowoc
- Wisconsin Society of Anesthesiologists, Sept 6-8, 1985, American Club, Kohler
- Wisconsin Society of Physical Medicine & Rehabilitation, Sept 11, 1985, Sheraton Inn, Milwaukee
- Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting, Sept 12-14, 1985, Pioneer Inn, Oshkosh
- Wisconsin Surgical Society, Sept 13-14, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Neurological Society, Sept 27-28, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Otolaryngological Society, Head and Neck Surgery, Sept 28-29, 1985, Heidel House, Green Lake

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

AUGUST 1–4, 1985: *Second Annual St Paul-Ramsey Trauma Conference* (Fishing & Family Recreation), Fox Hills Resort, Mishicot. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3/85

AUGUST 1–4, 1985 (Georgia): *International Doctors in Alcoholics Anonymous Annual Meeting.* Hyatt Regency Hotel, Savannah. Reservations may be made at a later date when specific details and instructions are published. For further information contact: Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44511; ph 216/782-6216. g12tfn/84

SEPTEMBER 5–7, 1985 (Texas): American Cancer Society, *Second National Conference on Diet, Nutrition and Cancer,* Shamrock Hilton, Houston. Info: American Cancer Society, Second National Conference on Diet, Nutrition and Cancer, 90 Park Ave, New York, NY 10016. g3-8/85

SEPTEMBER 17–18, 1985 (Illinois): *Medical Practice and Hospital Privileges,* at Chicago Marriott O'Hare, Chicago. Info: American Board of Medical Specialties, One American Plaza, Suite 805, Evanston, IL 60201; phone 312/491-9091. g12/84;1-8/85

AMA

JUNE 16–20, 1985: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 8–11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

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1985 Membership Directory

Members, watch your mail for a Membership Records Verification Form to update the information to be used in the 1985 Membership Directory to be published in the July issue of the *Wisconsin Medical Journal.* See pages 32 and 33 of this issue for further details.

HEALTH TRENDS as reported by the National Health Lawyers Association (NHLA) in its April issue of NEWS REPORT. *"The idea of buying medical care a la carte is not long for this world," Rep Ron Wyden (D-Oregon) told participants at NHLA's 6th Annual Institute on Medicare and Medicaid Payment Issues.* "More and more citizens and groups will insist on buying their care in packages," and as a result alternative delivery systems, such as preferred provider organizations (PPOs), and health maintenance organizations (HMOs) will experience substantial growth, Wyden said. Wyden predicted that the growth in alternative delivery systems will be spurred on by big business, "the brand new player in the health-field." "The fastest rising cost to American business today is healthcare," and many more businessmen are willing to spend an appreciable amount of their time in order to generate savings in this area, stated Wyden. Businessmen will be attracted to providers who are willing to put themselves at a financial risk in providing care, he said. Another trend which Wyden forecasts will make its way into Congress is an increased emphasis on prevention. He said that cigarette taxes would be viewed as user fees and earmarked for the Medicare program. Calling policies by which Medicare pays $50,000-$60,000 under Part A for the treatment of illnesses which could have been prevented if they were covered under Part B (*ie,* blood pressure monitoring) "absolute insanity," he said Congress will take action in the future to bolster prevention programs. *Wyden expressed concern "that cost containment not become care containment." One way to avoid this result is to continually push for new advances in technology, Wyden said, and to accomplish this goal, he favors a set-aside for quality enhancement.* Lastly, Wyden discussed malpractice reform. He believes that the no-fault approach proposed by Reps Gebhardt and Moore will lead to an explosion of lawsuits. In its place he offered a three-part proposal. "First," he said, "we need to do a better job in reporting nationwide those physicians and individuals found liable for malpractice. Secondly, we ought to concentrate on alternative systems so consumers will be given a choice, between traditional civil litigation and other alternatives . . . Thirdly, we need to make sure that savings from malpractice reform are actually passed on to consumers."

Rep Willis D Gradison, Jr (R-OHIO) called the proposed Medicare freeze on hospital and physician fees "a breach of faith by the Administration," at a National Health Council meeting April 2. He suggested the following alternatives to hold down healthcare costs. First, he supports the Prospective Payment Assessment Commission's recommendations regarding the adjustment in the DRG rates. The Commission recommended that HHS update the Medicare rates by the increase in the hospital market-basket, a measure of inflation, with adjustments for productivity, technology advancements and case mix. Secondly, Gradison said that both Medicare Part A and Part B benefits should be taxed. This would produce $500 million in fiscal 1986, and $1 billion for each year thereafter. Thirdly, he said mandatory second opinions for elective surgery should be required and could save Medicare more than $1 billion. Lastly, Medicare should move away from retrospective reimbursement for capital to a system whereby the capital payment would be tied to the hospital's volume of business, he said. In regard to physician reimbursement, Gradison stated *"physician DRGs may not ever happen and certainly won't happen in 1985, but it may be possible to experiment with DRGs for certain medical procedures;* ie, *surgery." Gradison does not believe DRGs are the ultimate solutions for financing the nation's healthcare.* As a form of rate regulation, they go against his procompetitive beliefs, he said. He is more optimistic about the HMO voucher program, and says that, if it is successful, he would like to see the program broadened for all beneficiaries. "The HMO voucher program may prove more long-lasting than DRGs," he stated.

"Major problems exist in regard to the deficiencies in the original data that was used to put the Prospective Payment System (PPS) together—data used to construct DRGs, data used to calculate DRG weights and standardized amounts, data used for construction of wage indices, and data used for adjustment within the system," Dr Donald Young, executive director of the Prospective Payment Assessment Commission (ProPac), told participants at NHLA's Medicare and Medicaid program. "This will be a continuing problem," according to Young, and "as we move forward we will have to balance the costs of acquiring new and better data with the value of that data for its use in maintaining and updating the system."

continued

A General Accounting Office (GAO) preliminary report concluded that Medicare's new prospective payment system has resulted in the premature discharge of hospital patients. Sen John Heinz (R-Pennsylvania), chairman of the Select Committee on the Aging, commissioned the report, "Information Requirements for Evaluating and Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report." He said the study showed that in many cases patients were going home to a "no-care zone" where alternative levels of care are not available. Among the report's other conclusions were: 1) that shortages of nursing home and home health services in many communities could result in denial of care to "heavy care" and Medicaid-eligible patients; 2) that even in communities where nursing home and home health services do exist, they may not be equipped and staffed properly to care for the sicker patients whom they see today; and 3) that treating relatively ill patients outside the hospital may cost more than leaving them in the hospital, and is likely to increase beneficiaries' out-of-pocket costs in either case. The conclusion of the GAO report was affirmed by a survey of state nursing home ombudsmen. Completed by three-fourths of all ombudsmen, the survey found that 77% said that patients were being discharged "sicker or much sicker" than before DRGs. More than half of the respondents said skilled nursing care was not adequate to meet the needs of discharged patients in rural areas and one-third said this care was inadequate in urban areas.

The Reagan Administration plans to encourage the development of private insurance for nursing home care for the elderly, and thereby reduce Medicare and Medicaid expenditures, according to the NHLA's April NEWS REPORT. These two programs paid about half of the $29 billion the nation spent on nursing home care in 1983. Studies commissioned by the Department of Health and Human Services have concluded that private insurance could produce substantial savings for the government. Long-term care is presently considered the largest gap in Medicare. Under the present programs elderly people must virtually impoverish themselves, by spending or giving away most of their resources to qualify for Medicaid, and the criteria for Medicare are so restrictive that comparatively few nursing homes have participated in the program. Thus, department officials believe that there is a large potential market for private insurance for nursing home services. *Elderly people from middle income families, as well as their children, could be expected to purchase long-term care insurance, department officials said.* According to ICF Inc, a consulting firm that investigated the "private financing of long-term care" under a contract with the department, "premiums in the range of $400 to $700 a year for someone age 75 just starting to purchase such a policy would appear to be manageable by an increasing number of elderly concerned about exhausting their resources." Nursing home care typically costs between $60 to $150 a day. Gerald H Britten, a Deputy Assistant Secretary of Health and Human Services, said private insurance for long-term care would lead to "more consumer choice, more innovations" in the delivery and financing of long-term care while alleviating some of the financial burden borne by Federal and State governments. Insurance industry spokesmen warn, however, that private long-term insurance would create a new demand for nursing home care, and thereby set off further inflation in medical costs. ■

PHYSICIANS MORE AWARE OF CHILD SEXUAL ABUSE. Physicians are more aware of child sexual abuse now than they were before 1984, but some who suspect such abuse still hesitate to report it. An opinion poll of 1000 physicians appearing in the April 12, 1985, edition of *American Medical News* shows that 76 percent of 214 physicians responding reported greater awareness of the issue than in the past. About a quarter of the physicians suspected they had seen cases of child sexual abuse in their practices, but fewer than that said they had actually reported their suspicions. Among the reasons physicians cited for their hesitancy in reporting child sexual abuse were inadequate training to recognize signs of abuse and insufficient evidence to document abuse. Some physicians said they preferred to deal directly with the child's family than to go to authorities, and other physicians said the abuse had been reported by someone else. Only two percent of physicians who did not report suspected abuse said that fear of legal repercussions held them back.■

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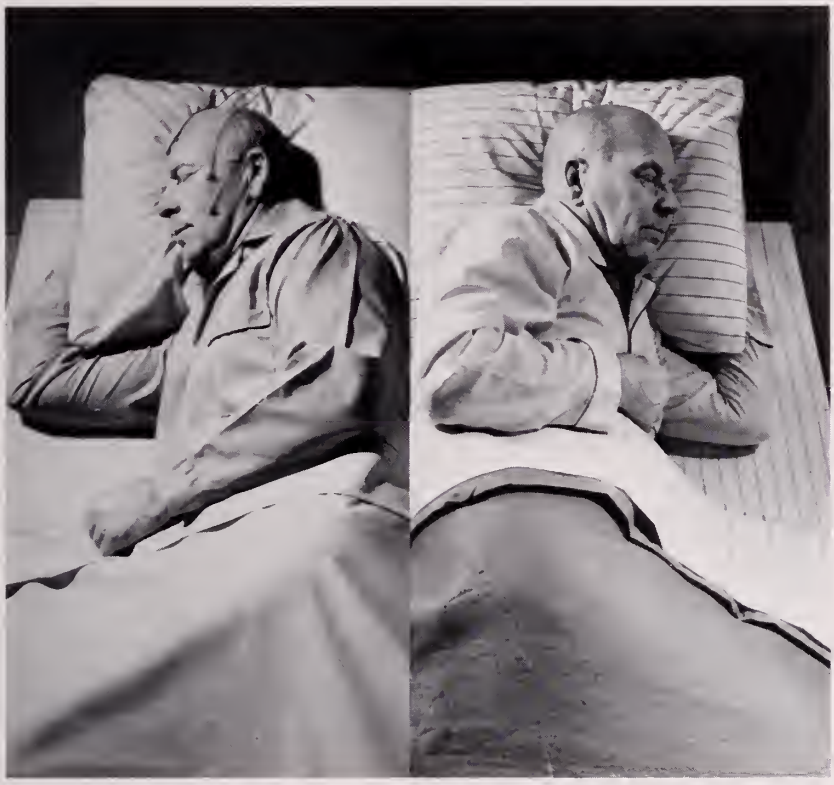

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V.84, NO.6

Blue Book issue . . . A reference source on medicolegal, socioeconomic, legislative, governmental matters of direct concern to the physician. Also a reference source on State Medical Society organizational structure, other related organizations, and state governmental agencies

Special features . . . Malpractice, countersuits, fee splitting, peer review, summary report of House of Delegates' actions

JUNE 1985

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CONTENTS

June 1985

SPECIAL FEATURES

Editorials

8 The case mix index
Wayne J Boulanger, MD
Milwaukee

Changing of the guard
Victor S Falk, MD
Edgerton

Time's-a-wastin'
Victor S Falk, MD
Edgerton

Letters

14 The public, malpractice, the Wisconsin Patients Compensation Fund, and us
Richard D Sautter, MD
Marshfield

Fee discrimination
Robert L Schwarz, MD
Menomonee Falls

Tourette Syndrome
Dr and Mrs Richard H Ward
Appleton

"BLUE BOOK" FEATURES

23 *Wisconsin Medical Journal* "Blue Book" 1985

24 State Medical Society of Wisconsin: Officers and Directors, Delegates and Alternates to the AMA

25 Countersuits

30 Helping the retarded, developmentally disabled person

31 Medical liability—A physician's rights and responsibilities

33 Medical malpractice: A dilemma in the search for justice
Robert J Flemma, MD
Milwaukee

41 Legal aspects of peer review
Susan M Schmidt, JD
Chicago, Illinois

43 Peer review in Wisconsin

44 How to get health-related information in Wisconsin

45 Statewide Impaired Physician Program

47 Mediation and peer review services of the State Medical Society; protocol manual

53 Wisconsin adoption agencies

53 Wisconsin Poison Control Program Network

54 Wisconsin's fee splitting statute

58 Recently enacted communicable disease laws

59 List of communicable diseases by category

59 AIDS

60 Legal responsibilities of the physician-patient-hospital relationship

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84 No. 6

CONTENTS

62 Retention and inspection of patients' records

68 Consent to release medical information (form)

68 Patients' right of access to their medical records

69 "Denial of Access' forms

70 Questions about medical records laws

72 NOTICE: Wisconsin hospital emergency rooms and outpatient facilities are aware of the following federal and state laws which prohibit . . .
1) Discrimination against patients
2) Refusal of admission

72 Hospitals required to report physician's loss of hospital staff privileges to Medical Examining Board

73 SMS members, you should know—
- Abortion
- Abused Child Law
- Adoption process in Wisconsin
- Adoption Records Law
- Autopsy
- Certification
- Child safety restraint systems
- Closing a physician's office
- Communicable diseases
- Consent and related forms for physicians
- "Denial of Access" to healthcare records
- Determination of death
- Disability claims
- Donations of organs, body (uniform organ donor cards and decals; donation of eyes; "living will" on use of measures to sustain life)
- Drivers' licenses for epileptics
- Drug Substitution Law
- Elderly abuse
- Employees allowed to inspect records under law
- Good Samaritan Law
- Implied Consent Law

The *Wisconsin Medical Journal* gratefully acknowledges publication support of this "Blue Book" issue through a contribution from the **Crownhart Memorial Account** of the State Medical Society's Charitable, Educational and Scientific Foundation.

FRONT COVER. . .Physician-artist Fevzi Pamukcu, MD of Kenosha has depicted here the tension and imbalance which have developed between the medical profession and legal system. In his oil painting, the physician is shown trying to right the balance which has been tipped in favor of huge dollar awards for malpractice claims. The gavel of justice is seen to be poised in a blow struck at the caduceus, the ancient symbol of the medical profession.

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5600 member physicians in Wisconsin, comprising 55 county medical societies and 25 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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continued

- Jail health care in Wisconsin
- Joint practice: physicians and nurses
- Jury duty
- Licensure in Wisconsin
- Living wills—the Natural Death Act, Chapter 154
- Medic Alert Foundation International
- Minor's consent
- Newborn infant eye drops
- Opening a physician's practice
- Optometrist referral law
- Patients' records/retention and inspection
- Patients' right of access to their medical records
- Physical therapy relating to practice
- Physician-patient-hospital relationship
- Physician's Assistants (PA)
- Premarital examinations
- Standard casualty medical report form

80 Let these guides help you

81 Physician licensure verification procedure

81 Physician re-registration

82 Alternate modes of treatment

83 Use of consent and related forms for physicians

90 Must a Wisconsin physician report . . .

91 Unprofessional conduct defined

92 Some considerations before opening a physician's office

93 Some considerations in the closing of a physician's practice

94 Problems of a physician's widow/er

96 Important notice to physicians and clinics re toxic substances and infectious agents

97 Wisconsin Clearinghouse (for information on alcohol and other mood-altering drugs, etc)

97 Narcotics

98 Attending a physician's return-to-work recommendations record

98 Alcoholics Anonymous

100 Accreditation Program for Continuing Medical Education

State Medical Society of Wisconsin

102 Charter Law of Medical Societies

103 Constitution and Bylaws of the State Medical Society of Wisconsin

108 American Medical Association—Principles of Medical Ethics

109 Expense reimbursement policy and procedure for physicians on State Medical Society business

110 The Oath of Hippocrates; Declaration of Geneva

111 Medical Ethics

112 Charitable, Educational and Scientific Foundation

113 CES Foundation: Officers, Board of Trustees, Nonmedical Trustees, and Corporate Members

114 CES Foundation: Contributions during the month of April 1985

115 Facts . . . about the CES Foundation Student Loan Program

116 "The Beaumont 500" Club

118 Board districts and directors: 1985-1986

118 SMS Placement Service aids physicians and communities

119 Officers and directors: 1985-1986

120 Board of Directors Committees: 1985-1986

120 SMS Services, Inc: 1985

120 SMS Auxiliary: 1985-1986

120 Past Presidents of the State Medical Society of Wisconsin

121 Officers and Directors: 1985-1986 (pictures)

122 Commissions and Committees: 1985-1986

126 1985 Physicians Alliance Districts and Field Consultants

continued

127 Wisconsin Physicians Political Action Committee

128 County Medical Societies: Presidents and Secretaries, et al

131 Special Sections of the State Medical Society: Officers

133 Specialty Societies in Wisconsin: Presidents and Secretaries

State Government Agencies

143 Department of Health and Social Services
- Division of Health
- Division of Community Services
- Division of Vocational Rehabilitation
- Division of Care and Treatment Facilities

146 Department of Regulation and Licensing
- Bureau of Health Professions
  —Medical Examining Board
  —Dentistry Examining Board
  —Pharmacy Examining Board
- Bureau of Nursing
  —Board of Nursing

146 Department of Industry, Labor and Human Relations

147 Health Policy Council

148 Wisconsin Health Systems Agencies; Physician members of Wisconsin Health Systems Agency Boards

149 Wisconsin Peer Review Organization (WiPRO)

151 Membership facts

ORGANIZATIONAL

152 Doctor Scott installed SMS president; Top priorities: Malpractice reform, membership; Election results; New directors

153 Doctor Charles Landis, Milwaukee, is president-elect

154 Board of Directors April meeting highlights; New Editorial Board member; SMS Secretary issues call for tougher peer review

155 Some controls needed; House of Delegates highlights

157 Medical Museum season began May 1

158 Summary report of SMS House of Delegates, April 25-26, 1985, La Crosse, Wisconsin

166 Medical School deans receive Directors Award

167 Outstanding medical students receive Houghton Award

168 Corporation recognized for support of primary care; Interstate Teaching Award goes to Doctor Sandmire

169 Maryland physician recipient of Beaumont Award; Doctor Jowsey delivers Elvehjem Lecture

170 Society honors long-time employee; Scientific Exhibit Awards

171 The "Beaumont 500" Club

172 New Fifty-Year Club members

173 SMS Task Force on Medical Care

174 Report of President Scott to House of Delegates: A full and promising agenda already laid out

177 Report of Outgoing President Flaherty to House of Delegates: Our number one priority is malpractice reform and that's coming!

181 Report of Secretary Thayer to the House of Delegates: The problem of competence or incompetence

DEPARTMENTS

18 Principles of Advertising: *Wisconsin Medical Journal*

18 Publication information

185 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Miscellaneous . . . Medical meetings . . . Continuing Medical Education . . . Advertisers■

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The case mix index

DRG REIMBURSEMENT is based in part on the complexity of the problem. From the very beginning even HCFA recognized that not all cases of pneumonia or appendicitis follow a predictable course. Taking this into account, the case mix index was developed. The record of each hospital over a three-year period was scrutinized with the idea of assessing the severity of illness experienced by its patients. If a certain hospital attracted patients with just average ailments in that three-year period, it was granted a case mix index of one. If, on the other hand, its patients tended to be more sick than average, the case mix index might be 1.1 or 1.2. Then the HCFA would multiply the DRG total dollars by 1.1 or 1.2 to determine the amount actually to be paid by Medicare. My hospital's case mix index turned out to be 1.087.

However, at the time all this was going on, doctors were changing their practices to accommodate the new system by admitting fewer, but sicker patients. It doesn't take Einstein to figure out what that does to the case mix index.

So far this year, my hospital's case mix index is 1.24 and rising while in 1984 it was 1.17. But payment is still being made on the basis of a severity index of 1.087. At my hospital, at least, HCFA has made no adjustment to compensate for the change, nor is any in the offing. This will lead to more personnel layoffs and further curtailment of patient services. Most hospitals are probably in the same fix. The hospitals need our help in application of pressure to induce change if we are to retain reasonable quality of care.

—*Wayne J Boulanger, MD,* Milwaukee

Changing of the guard

THE SMS BOARD OF Directors made some changes in appointments for the *Wisconsin Medical Journal.* Dr Wayne Boulanger was not eligible for reappointment to the Editorial Board, but the Board did reappoint him as editorial director. Thus, we will be able to still benefit from his pithy comments and bursts of poetry. Dr Andrew Crummy, Professor of Radiology at the University of Wisconsin Medical School, was appointed to replace Doctor Boulanger. Dr George Kindschi of Monroe was reappointed to the Editorial Board. Dr R Buckland Thomas, a psychiatrist with the Monroe Clinic, was appointed editorial associate. Doctor Thomas was formerly editor of the *South Carolina Medical Journal.* He replaces Dr John Mullooly of Milwaukee. Dr Raymond McCormick and Dr. Russell Lewis were reappointed editorial associates.

The staff of the *Wisconsin Medical Journal* thanks the former members for their service to and interest in the Medical Journal and welcomes aboard the new members.

—*Victor S Falk, MD,* Edgerton

Time's-a-wastin'

A MAJOR US manufacturing corporation with plants in Wisconsin has come up with a new requirement. Whenever an employee or family member requires hospitalization, permission must be obtained by calling Detroit. The company has 100 "800" numbers and a like number of operators. The initial problem is to get one of the "800" lines. For example, my office nurse called the Detroit number five times. After four busy signals she was put on hold on the fifth attempt. She then held for 45 minutes awaiting a response from the individual at the other end. Judging by the responses in Detroit, it is obvious that the operators have no medical background whatsoever. After providing the information about the patient along with the policy number, group number, provider number, the hospital location, etc, the operator deigns to allow a certain number of hospital days.

Recently I was allowed two days for a patient with acute appendicitis. If it becomes necessary for such an individual to stay in the hospital for a third or fourth day, one must again call the 800 number in Detroit and after the usual wait, request permission for the additional hospital days. Then a week or two later, one receives a computer-type letter authorizing the hos-

pital stay which has long since terminated.

One hundred hotlines and 100 operators do not come cheap. The time of physicians or their assistants apparently is regarded as of little or no value since my colleagues report periods of 35 to 50 minutes on hold. This is another strange way to cut the cost of medical care.

—*Victor S Falk, MD,* Edgerton

Editorial Board comment: *If only the patient/voter really knew what ripples (tidal waves) the strategies of the Federal Government healthcare agencies are/will be causing to the delivery of good medicine to the general public. Alas, their fate will be the same as those who live on/around the San Andreas fault. The full impact on both will only be apparent after the quake... We are all frustrated with similar preadmittance requirements. I guess we just have to hang in there!! Perhaps "medical marketing" will streamline some of these agonizing frustrations.*■

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1233 North Mayfair Road, Suite 301, Milwaukee, WI 53226 (414) 453-9070

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The Board wishes to thank all primary care physicians for their support and their adherence to the policies that have insured the continuation and growth of the only primary care physician-run HMO in Wisconsin.

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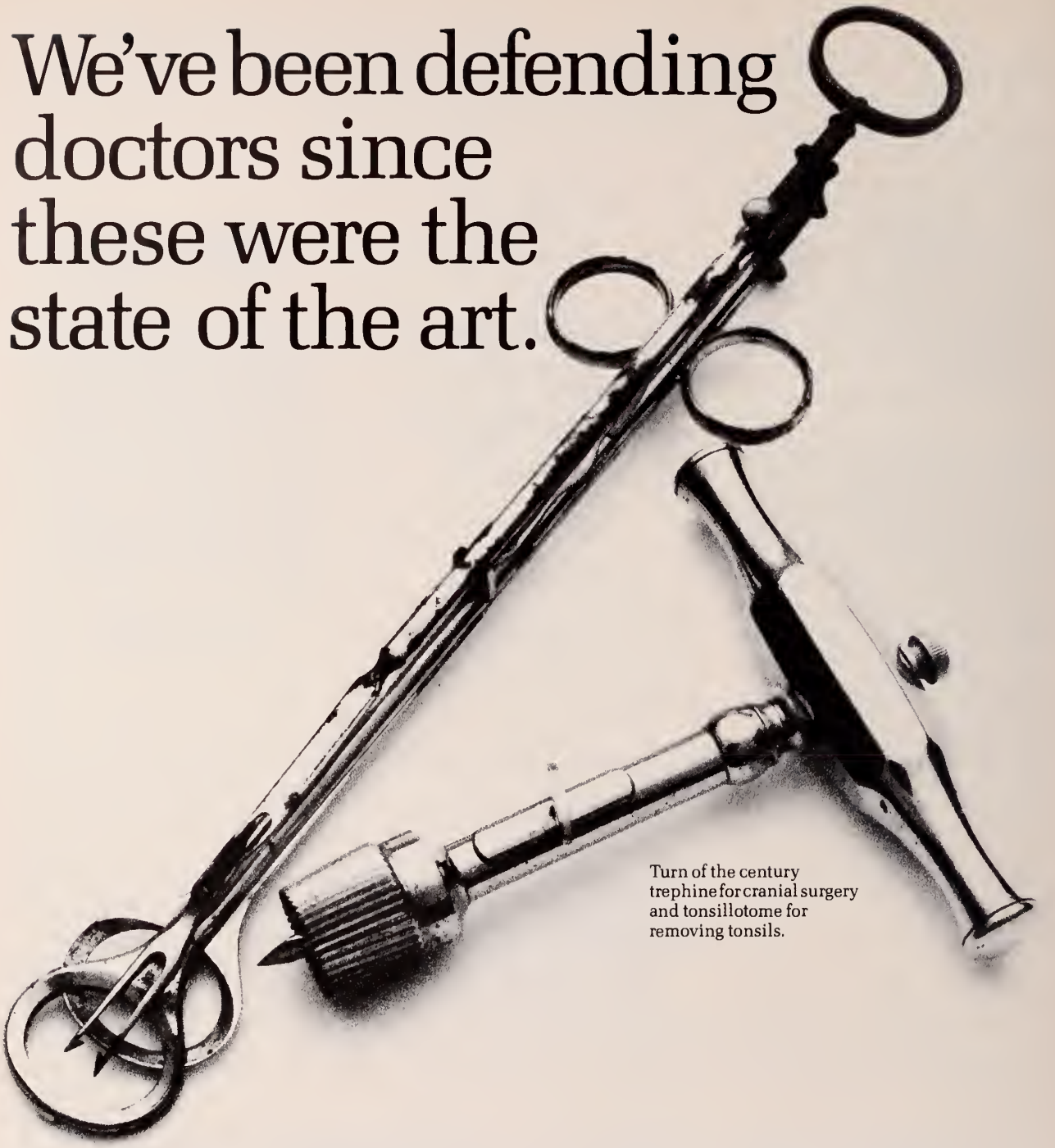

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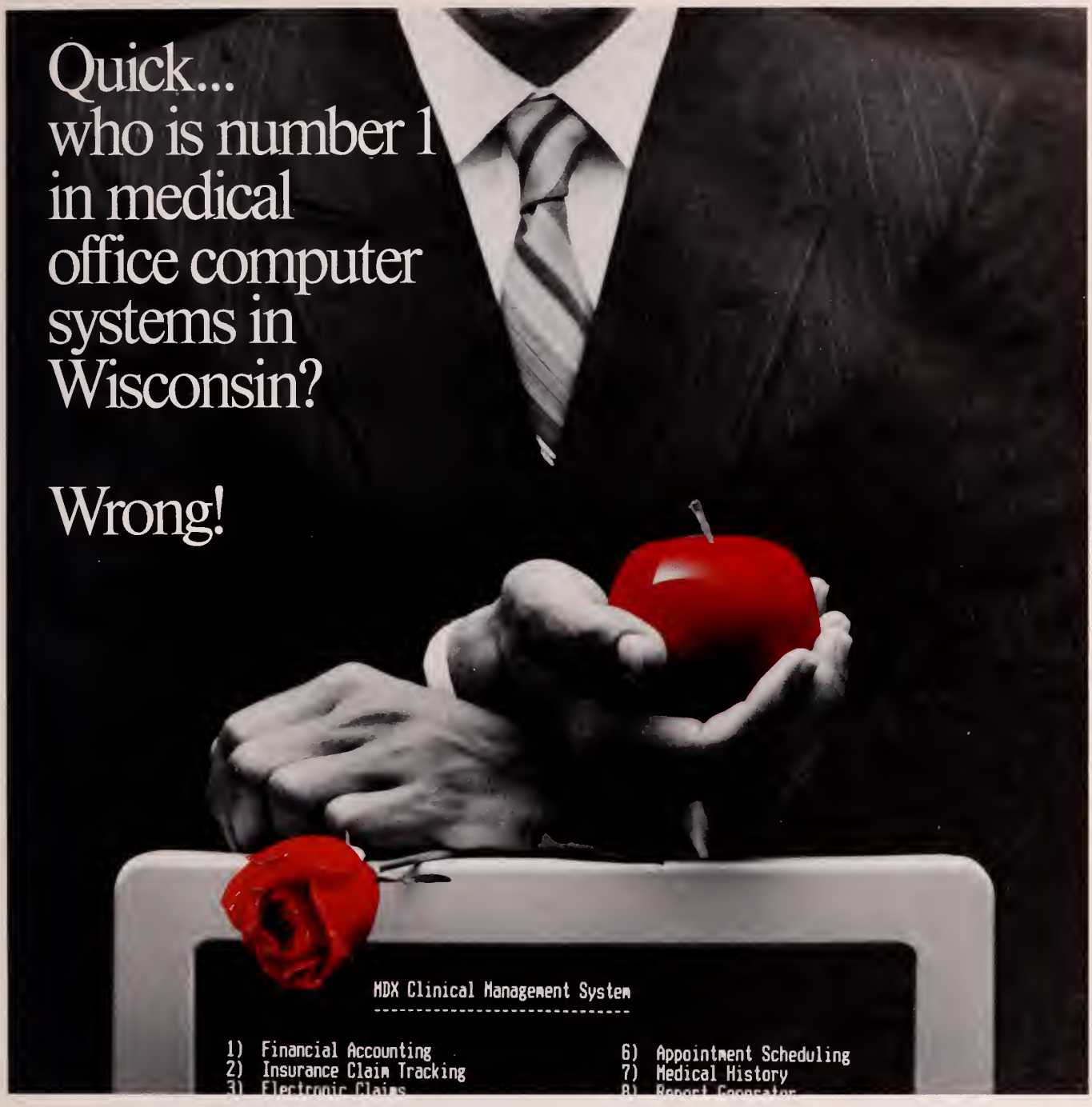

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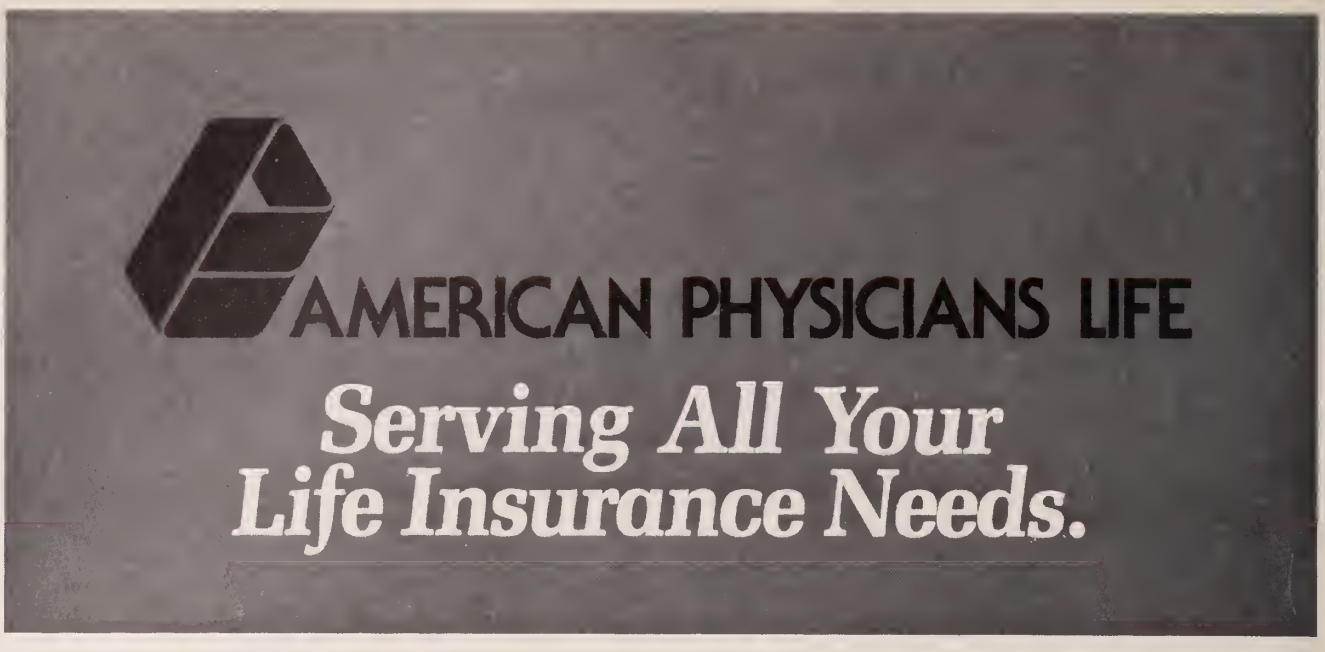

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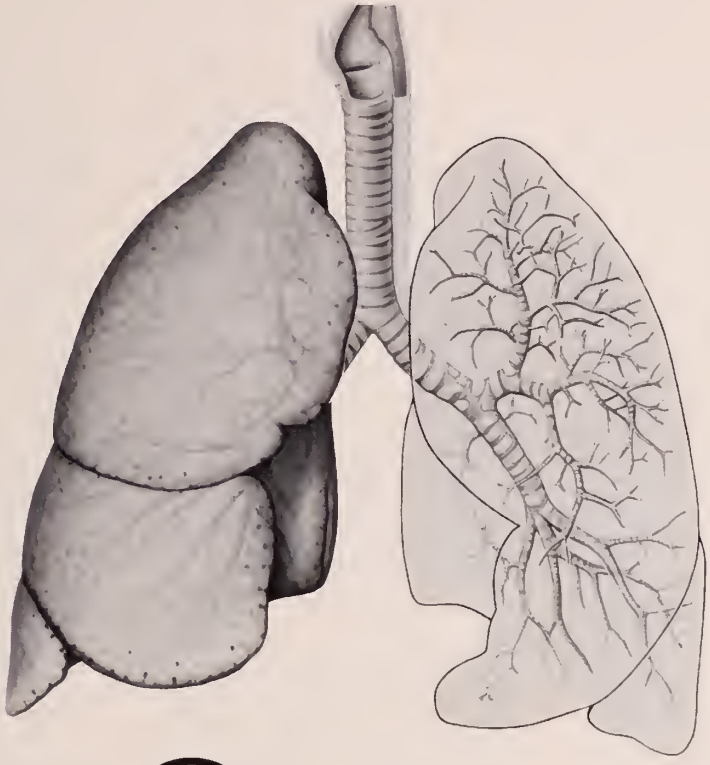

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Brief Summary: Consult the package literature for prescribing information

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Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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400441

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

The public, malpractice, the Wisconsin Patients Compensation Fund, and us

TO THE EDITOR: The public, politicians, trial lawyers, and physicians are all concerned about malpractice. Some individuals in each group accuse other groups and individuals of bad faith, conniving, misrepresentation, and so forth. Newspaper articles and editorials pick and exploit various points of view. There may be a grain of truth in all the various positions on this issue.

The State Medical Examining Board has been criticized. Comparisons were made with other boards and more activity was suggested. One wonders of the 400 odd cases the Medical Examining Board has under advisement, awaiting disposition, how many of these physicians have had malpractice claims against them. There is a financial incentive for the physicians in Wisconsin to weed out the incompetent practicing doctors. The Wisconsin Patients Compensation Fund (WPCF) needs to run "lean and mean" rather than "thin and grim" as it is presently. With the possible exception of some trial lawyers, the consensus is that something really ought to be done to correct the present situation regarding the huge escalation in premiums for the Wisconsin Patients Compensaton Fund.

Suggestions have been offered as to a solution and now action is needed. I believe an ideal solution would be to:

— protect the public from incompetent physicians,

—keep good physicians in practice (especially important in rural areas) by holding down premium payments,

— protect the Wisconsin Patients Compensation Fund from further dollar erosion and escalation of premiums, and

— reduce the number of frivolous claims.

I suggest the State Medical Society recommend the Legislature pass enabling legislation to establish a committee or panel with precisely this mission. Changing, modifying, or increasing the charge to the Medical Examining Board would be awkward, take too long, and probably wouldn't work.

This committee would review all malpractice claims, beginning obviously with those successful claims for the largest dollar amounts. But ultimately this would include even unsuccessful claims.

This legislation should give the committee the authority to:

— **rescind, or not offer,** Patients Compensation Fund coverage to any physician they judge to be unfit to practice,

— **rescind coverage selectively;** *ie,* not all thoracic surgeons should be doing open heart surgery, not all neurosurgeons should be doing intracranial vascular anastomosis, not all orthopedic surgeons should be doing spine surgery,

— **add surcharges** to the premiums of physicians who are outliers in the number of malpractice claims. The system needs to be fine-tuned. It is not reasonable that a neurosurgeon, gynecologist, obstetrician, or thoracic surgeon with no malpractice claims in five or ten years should pay the same premium as one who has had a claim per year.

It would be important for all the players, most importantly the Legislature, to understand our position is that there are circumstances when even an excellent physician can have a successful malpractice claim against him or her because we are, as physicians, also human. The question of how many successful claims against a single physician are evidence that he is incompetent has not been determined. What is known is that in ten years 21 physicians have had three or more successful malpractice claims filed. Are these physicians incompetent? Are they insured by the WPCF? How many dollars from the Fund were paid out for these 21 physicians? Are they included in those cases under advisement by the Medical Examining Board? Such questions could be answered by such a committee.

The number of physicians having two or more claims filed against them is not known. Perhaps the number of unsuccessful claims filed against an individual physician are also important because they may only reflect the quality of his/her defense attorney and not the issue of negligence.

The question of negligence needs to be addressed by the committee. Perhaps if gross negligence (which requires precise definition) is proved, a single malpractice claim is sufficient to withhold insuring that individual or doubling his surcharge.

This could be left to the judgment of the committee. Obviously, there would need to be peer representation to the committee in arriving at such decisions.

Important to consider is that maybe there are too many incompetent physicians practicing

in Wisconsin. There also may be too many trial lawyers, weak, easily influenced juries, and so forth. The committee could not successfully address all of these issues but could at least remove the Wisconsin Patients Compensation Fund from the risk of covering incompetent physicians.

Perhaps the committee should be authorized to take action against attorneys who file numerous frivolous claims either through the courts or the Bar Association. Perhaps a percentage of the Patients Compensation Fund should be set aside for rehabilitation of the impaired physician. Informing the patients of the malpractice problem would be worthwhile. Perhaps a general educational program on malpractice issues may be in order for *all* physicians. If physicians wished to continue receiving coverage from the Wisconsin Patients Compensation Fund, attendance could be made mandatory. Certainly the findings of the committee should be reviewed by the Medical Examining Board.

The composition of such a committee is critical. It is best to remember that large committees have an inherent inertia. Chairmen of such committees seldom get the work done without a substantial time commitment. Without authority, necessary actions don't take place. Without action, committee members rapidly lose interest. The committee must see decisions result in action. Halfway measures seldom get even halfway results. Without high quality and sufficient staff, failure could be predicted.

Our Society's immediate past president, Timothy T Flaherty, MD, and our current president as well, John K Scott, MD, recognize this problem; and during Doctor Flaherty's term he recommended establishment of a panel to do much of what I have recommended. Now what is needed is action.

—Richard D Sautter, MD
1000 North Oak Ave
Marshfield, Wisconsin 54449

Fee discrimination

TO THE EDITOR: Are you tired of the high cost of continuing medical education? Have you also noticed that many nonphysician health professionals are attending medical education conferences? Have you also noticed the other health professionals often pay greatly reduced fees for these same conferences?

For example, at a recent Sports Medicine conference at the University of Wisconsin-Madison, the fee for physicians was $165. The fee for nonphysicians was $85. Both nonphysicians and physician attendants received the same course booklets, heard the same lectures, and occupied the same amount of space in the conference hall. Yet, the physician pays almost twice as much money for this educational product. Is this fee discrimination really justified?

Even if we assume that all physicians are rich and all nurses, physical therapists, physician assistants, etc are poor, the price differential is unreasonable. Often, the registration fees are paid for by employers—that is, clinics, hospitals, and other institutions—whose expense accounts are far larger than the individual medical practitioner. In addition, if the nonphysician practitioner is self-employed and paying his or her own fee, is it fair for the MD to pay twice as much—in effect subsidizing the education of his competitors?

In any case, I resent having to pay twice as much for my continuing medical education as other health professionals.

Equal conference—equal fee.

—Robert L Schwarz, MD
N84 W16889 Menomonee Ave
Menomonee Falls, WI 53051

Tourette Syndrome

TO THE EDITOR: Our daughter, Susan, was 2½ years old when we first sought neurological evaluation for "unusual eye movements." When her problem was not identified, we assumed that we were doing things which made her nervous. Nine years later she was finally diagnosed as having Tourette Syndrome.

We urge all physicians who recently received the SMS mailing on Tourette Syndrome to carefully read the information on this disorder. Although many more physicians are knowledgeable about this not-as-rare-as-was-thought condition, many families are still spending thousands of dollars and years of frustration trying to learn why their child makes strange movements and sounds and has some other unusual behaviors, often to the point of its preventing the living of a normal life.

There are drug therapies which can help control TS. The benefits of early diagnosis and treatment are enormous in that frustration is more easily dealt with and the social and emotional aspects of the disorder can be managed more efficiently.

We thank the CESF and SMS for undertaking this educational project, and we urge all physicians to learn about Tourette.

—Dr and Mrs Richard H Ward
1821 N Racine Street
Appleton, WI 54911

EDITOR'S NOTE: The publication entitled "A Physician's Guide to Diagnosis and Treatment of Tourette Syndrome" is available by contacting the Charitable, Educational and Scientific Foundation (CESF), PO Box 1109, Madison, Wisconsin 53701.■

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P. mirabilis, Klebsietta* species, and enterococci (*S. faecatis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium ditficite* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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This article examines the countersuit concept as adopted by other state courts and the relative merit of the many legal doctrines found under the broad heading "countersuit." Finally, Wisconsin's frivolous lawsuit statute is examined for its potential assistance in the struggle to cope with malpractice "mania."

COUNTERSUITS

IT IS UNNECESSARY to introduce the idea that there is a malpractice lawsuit problem nationwide—only the most isolated members of society are unaware of the popularity medical malpractice claims have enjoyed over the past decade. Countersuits to malpractice suits started to appear about the same time and were first thought to be the meritless suit defendant's salvation. However, as the trial awards to countersuing physicians were subsequently reversed by appellate courts, it seemed that as the defendants remedy, the case for countersuits might have been overstated. Hope does remain in Wisconsin because the higher courts (having precedential value and therefore creating "case law") have not yet addressed countersuits to medical malpractice suits and therefore have not rejected their use.

What is a countersuit?

A countersuit is a lawsuit a defendant in one action brings against the plaintiff in that original suit, the plaintiff's attorney or both to compensate the defendant for injuries suffered as a result of the original suit. Countersuit plaintiffs, hence referred to in this paper as defendants, have based their right to redress on a number of legal theories. This paper will outline the most common legal theories and describe their relative success in other jurisdictions.

Malicious prosecution

The most frequently used doctrine, malicious prosecution originated in criminal law and has been applied more recently to civil law matters. Defendants bringing malicious prosecution suits must plead and prove four factors:[1]

(1) the original (underlying) suit must have terminated in the defendant's favor;
(2) there must have been no "probable cause" for bringing the underlying suit;
(3) plaintiff brought the original suit out of malice; and
(4) defendant suffered special injury.

Requirement 1: Favorable termination

Courts have defined "favorable termination" to mean that the suit was terminated because the merits were insufficient to support the malpractice claim. Termination can mean either that the suit was dismissed before reaching trial or that the suit terminated with a jury verdict for the defendant physician. Voluntary dismissals are not favorable terminations because, unless the claim was dismissed "with prejudice," the plaintiff may bring the action again. Even if the claim is dismissed with prejudice, the plaintiff's attorney might not be liable to the physician for malicious prosecution. In *Zeavin* v. *Lee,*[2] a court found that no malicious prosecution claim arose if the attorney filed and diligently prosecuted defendant's case, even though the case was dismissed due to the plaintiff's refusal to comply with discovery procedures. Although the requirement that the prior suit was terminated in the physician-defendant's favor seems straight-forward, courts might yet qualify the case and dismiss the countersuit action.

There is some question whether a Patient's Compensation Panel decision in the respondent physician's favor would constitute a favorable termination because termination means that the plaintiff must be foreclosed from bringing the same claim again in court. Because a plaintiff who loses at the panel level can then appeal to the trial court for a de nuovo trial on the facts, the claim has not been extinguished in the same manner as a dismissal, or trial on the merits extinguishes a claim and bars the plaintiff from bringing the claim anew. Therefore, it is most likely that unless the physician has prevailed at the trial court level through a dismissal, favorable jury verdict or other final decision, he or she probably cannot prove this first element of malicious prosecution.

Requirement 2: Probable cause

Probable cause is even more troublesome for a defendant countersuing under the malicious prosecution theory. Probable cause essentially means reasonable cause—whether the plaintiff had reason to bring the malpractice suit. Lack of probable cause has been found in a malicious prosecution action against the plaintiff's attorney when the attorney disregarded relevant circumstances and failed to properly investigate client's claim before filing a malpractice suit. In *Moiel* v. *Sandlin,*[3] the Texas appellate court stated:

> An attorney may generally rely in good faith upon the facts his client relates. Unless lack of probable cause for a claim is obvious from the facts disclosed by the client or otherwise brought to the attorney's attention, he may assume the facts disclosed are substantially correct." (*Moiel,* at 570.)

Courts are more than slightly reluctant to impose on an attorney a meaningful duty to investigate. In *Fee, Parker & Lloyd, P.A.* v. *Sullivan,*[4] the Florida appellate court reversed a $175,000 award to a physician, stating that the attorney need only have probable cause to believe the physician was guilty to file the claim and that the trial court had evidence to that extent. Good faith will exonerate the client as well.

If the client relies upon the advice of his or her attorney in filing an action, he or she is relieved from civil liability.[5] Therefore, showing lack of probable cause goes beyond showing that the claim filed was not adequately supported by evidence because all that the plaintiff and his or her attorney need to show was that they were reasonable and acted in good faith when they filed the action.

Requirement 3: Malice

Courts differ in their definition of malice from state to state. Malice can be judged either by a subjective ("actual malice" or "malice in fact") or an objective ("inference of malice") standard. Actual malice is defined as an evil or sinister purpose, or wicked or malicious intent[6] and requires the plaintiff to prove the defendant's state of mind, that the defendant acted maliciously and intended to harm the plaintiff. For obvious reasons, proving malicious intent is difficult, and consequently many state courts have turned to the objective malice standard.

An example of a relaxed malice standard is California's inference of malice standard, a standard that the defendant meets by showing that the plaintiff lacked probable cause for filing the action.[7] However, the high threshold for establishing probable cause is often so great a hurdle that even the inference test is no savings to the defendant countersuing under the malicious prosecution theory.

Requirement 4: Special injury

Finally, the defendant, now countersuit plaintiff, must prove special injury. Although each of the four requirements pose definitional and proof problems, the special injury element is probably the most difficult to plead and prove in this state. Wisconsin is in a large minority of states that follow the "English rule" of damages.[8] This damages rule requires the plaintiff to prove that damages go beyond those ordinarily associated with defending a civil action.[9]

Under the strict English rule, it is necessary to demonstrate interference with the plaintiff's person (arrest), property (seizure), or other special interference to prove special injury. If interference cannot be shown, a malicious prosecution claim is absolutely barred. This definition is sufficiently ambiguous to allow a court uncomfortable with a counterclaim to deny the suit without reaching the suit's merits. What this means is that a physician might not be able to get past the complaint filing stage of litigation because the court finds that damages as pleaded on the complaint are not sufficient to warrant a malicious prosecution action. As a result, the special damages rule has virtually eliminated the malicious prosecution tort and its use as a countersuit remedy in other states, and will probably lead to the same result in Wisconsin.

Abuse of process

Abuse of process is the intentional misuse of a court process for some ulterior or collateral purpose unintended by law. Unlike malicious prosecution, the underlying case need not terminate in the plaintiff's favor nor must lack of probable cause for bringing the suit be pleaded or proved. However, it is not enough that the original suit was groundless if it was brought in the technically correct manner. The plaintiff must show that the defendant had an ulterior motive for bringing the underlying suit, i.e. to coerce a settlement. Because it is difficult to prove this sort of motive, abuse of process is generally unsuccessful and infrequently used.

There has been one successful countersuit based on abuse of process. In *Bull* v. *McCuskey,*[10] a physician sued an attorney for damages for abuse of process. The physician claimed that the attorney instituted a malpractice suit against him to coerce a nuisance settlement although the attorney knew that there was no basis for malpractice claim. The jury awarded the physician $35,000 as compensatory and $50,000 as punitive damages. Upon appeal to the Nevada Supreme Court, the court upheld the jury verdict, reasoning that the attorney's offer to settle the malpractice case for $750, his failure to investigate the claim before filing the suit, and his failure to present any expert evidence at trial supported the conclusion that the attorney abused the legal process.

Abuse of process has been used as a counterclaim to a suit. (A counterclaim differs from a countersuit in that it is alleged by the defendant as an answer to the malpractice plaintiff's complaint.) In one case,[11] a physician sued a patient to recover an uncollectable bill for a myelogram from the patient-defendant. The patient in turn sued the physician for medical malpractice. The physician counterclaimed that the patient filed the suit solely to avoid paying his bill, and that because of this abusive use of the legal process, the physician sustained damage to his reputation and expenses in defending himself in the malpractice action. Shortly after the counterclaim was filed, the patient dropped the malpractice suit and settled with the physician on the claim for payment of services.

Negligence

Countersuits brought against attorneys for negligence have become more popular. This form of countersuit has two sources for negligent conduct:

(1) the attorney's duty to third parties to exercise reasonable care when advising clients to file a malpractice lawsuit; and

(2) the attorney's failure to comply with the Code of Professional Responsibility of the American Bar Association that prohibits instituting frivolous litigation,[12] and potentially in Wisconsin, the Wisconsin Supreme Court Rules that prohibit the same conduct.[13]

Both allegations depend on the court's acceptance of the notion that attorneys owe the third party, the defendant physician, a duty to refrain from bringing unfounded litigation. However, courts have found that attorneys owe this duty to their client and the

legal system, but not to third parties so as to form the basis for a lawsuit.[14] In *Bickel* v. *Mackie,*[15] the court found that an attorney's liability to a third party is not based on a negligence standard. The court reasoned that an adverse party cannot depend on the opposing attorney to protect him or her from harm because the adversary system did not intend this duty to exist. Moreover, extending a duty under the attorney code of professional responsibilities would raise a direct conflict of interest regarding the attorney's primary duty to protect his or her client's interests. Therefore, there is no such thing as a negligence countersuit according to the courts.

Even if a negligence countersuit were recognized, it is unlikely that a court would find a lawyer negligent. Part of the problem is developing a standard for attorneys concerning their duty to investigate claims before filing an action. Because few if any countersuit negligence claims have reached trial, no negligence standards as yet have been established by courts. It would be safe to say that should negligence develop into a cause of action for physicians in the countersuit context, the standard would most likely be lenient.[16]

Barratry

Few countersuits[17] have raised allegations of barratry, that is, alleging the offense of "frequently exciting and stirring up quarrels and lawsuits."[18] Barratry is not used as a countersuit legal theory because it is considered a public rather than private remedy, meaning that it is used only to punish a lawyer for a general practice behavior and not for a single meritless malpractice suit.

Defamation

Defamation is defined as the invasion of one's interest in reputation and good name in the community through publication or communication of false statements to a third party. Statements made in the judicial process are privileged. What "privilege" means is that statements made in this judicial context do not constitute defamation. Included in the definition of judicial process is the malpractice allegation or allegations made in the complaint filed by the plaintiff and on record with the court. Since the media usually have access to the court records, including the original malpractice complaint, if the allegations are published, the defendant has not been defamed even if he or she wins by virtue of a jury verdict or court dismissal. However, defamatory statements made outside of the judicial proceedings receive no such protection. In other words, if the attorney for the malpractice plaintiff makes false statements to the press outside the courtroom, the attorney could be liable for defamation.[19]

This privilege bestowed upon statements made in the judicial process generally precludes defamation claims in countersuits. However, one case did succeed under the defamation theory when statements were made out of court. In *Jankelson* v. *Cisel,*[20] a dentist recovered $12,000 in a defamation (libel and slander) suit against a former patient who had complained to other dentists, dental societies, and government agencies about her treatment by the plaintiff. The defendant's defamatory actions took place before she initiated two malpractice actions. The first suit was voluntarily dismissed and the second, a counterclaim to the defamation action, was dismissed by the court. The court enjoined the defendant from any further libellous activities to protect and vindicate the dentist.

Invasion of Privacy

Invasion of privacy has been used by countersuing physicians to attempt to prove actual damages in malicious prosecution countersuits.[21] However, like defamation, invasion of privacy actions[22] does not apply to injury suffered as a consequence of the judicial process despite the fact that the suit was groundless.[23]

Prima facie torts

New York state has developed its own brand of tort—the prima facie tort, meaning "intentional malicious injury to another by otherwise lawful means without economic or social justification, but solely to harm the other."[24] The elements of this cause of action as formed by courts are (1) an intent to harm on the defendant's part; (2) a lack of justification for the defendant's actions; and (3) special damages.

Prima facie tort has not been viewed favorably by courts partly because it suggests a way to fix an otherwise defective malicious prosecution suit, supersede the privity (duty) requirement of negligence actions and preempt state tort legislation to the contrary. Moreover, prima facie tort as a countersuit claim has not functioned well in the state that nurtured it. In *Hoppenstein* v. *Zemek,*[25] the court held that the plaintiff had failed to plead special damages. Moreover, there had been no showing of "intentional infliction of economic damage without excuse or justification."[21] In *Belsky* v. *Lowenthal,*[26] the court refused to accept the prima facie tort rationale in the countersuit context, stating that "this rationale should not be an occasion for setting aside large bodies of case law which have defined our limits, established our guidelines and set forth the elements of traditional tort."[27]

One case in New York gave prima facie tort theory a short-lived success. In *Drago* v. *Buonagurio,*[28] the appellate division court overturned the trial court's dismissal of a countersuit using the prima facie tort theory. The physician defendant, now countersuit plaintiff, sued for prima facie tort the plaintiff who instituted a malpractice action that named the physician among those responsible for a wrongful death although the physician was not directly or indirectly involved. The appellate court agreed that no traditional tort theory gave a basis for the countersuit but reasoned that "the law should never suffer an injury and a damage without a remedy."[29] However, upon appeal to the Court of Appeals of New York, the case

was reversed, the court agreeing with the trial court that the complaint did not state a cause of action. The court deferred to the legislature to devise new liabilities and added that the court should exercise "judicial restraint in response to invitations to recognize what is conceded to be perhaps a 'new, novel or nameless' cause of action."[30]

The "new, novel or nameless" cause of action has had its day in court in other states. A prime example of this new tort was temporarily ensconsed in Illinois after a trial court awarded damages to a countersuing physician in *Berlin* v. *Nathan.*[31] In that famous case, the plaintiff claimed that the state constitution which provides that for every wrong there is a remedy[32] supported his countersuit. Upon appeal to the Illinois Appellate Court, the physician's claim was rejected. The court held that so long as some remedy for alleged wrong exists, the constitutional provision does not mandate recognizing any new remedy.[33] Since then, other courts have concurred that new tort liabilities do not exist simply because the state constitution allows for redress for wrongdoings.[34]

As for tort theories upon which countersuits have been hung, many claims have been made limited only by the physician's counsel's imagination. Like the prima facie and constitutional tort, many have been rejected. Certainly, there must be some reason for court reluctance to recognize countersuits in general. The main reason is a basic policy behind the judicial system discussed in the next section.

Public policy that counters countersuits

Why have countersuits received such a cold reception by trial and, particularly, appellate courts? The chief reason for this judicial resistance is that the idea that defendants should have recourse against plaintiffs who bring suits against them clashes with the public policy that all persons must have free and unfettered access to the courts "in order to settle their grievances."[35] This policy holds that "the courts should be open to litigants for settlement of their rights without fear of prosecution for calling upon the courts to determine such rights."[36] For the judicial system in this country to fulfill its constitutional mandate, plaintiffs and their attorneys must not be fearful that they will be liable to the defendant if their case does not have the necessary merit to prevail in court. If permitted to flourish, countersuits, it is argued, will "chill" the right to free access to the courts.

Another policy that works against countersuits acceptibility concerns court economy and efficiency. If every defendant who wins in the initial suit brings a countersuit, litigation would increase and further clog the already congested court dockets. If the defendant-now-plaintiff then loses, the original plaintiff then might countersue, and on and on. The result is unending litigation with cases taking not years but decades to reach the trial court stage.

Courts seem to recite these policies of judicial access and efficiency without recognizing that both policies have a flip-side. Are not defendants' right to redress in court for a wrong "chilled" by court reluctance to recognize countersuits? Considering the great expense involved in defending against malpractice claims, defendant physicians to meritless suits are being denied a recovery for injury suffered at the hands of the malpractice plaintiff when courts dismiss countersuit claims. Plaintiffs certainly must be given their day in court, but after plaintiffs have exercised this right, why should the defendants then be denied the same?

In the same manner, the judicial efficiency policy leaves questions unanswered. Obviously, there has been a major increase in malpractice claims filed over the past decade. Ten years ago there was evidence that a majority of malpractice claims were unfounded.[37] Unless the quality of medical care has plummetted to match the increase in claims filed, it is likely that a good share of claims filed today are meritless. Apparently, judicial efficiency is not enhanced by the current status of medical malpractice litigation in this country.

It could be argued that the problem posed by medical malpractice litigation's popularity does not lie with the judicial process so much as with state tort law. Considering state courts' unwillingness to create new tort doctrines,[38] perhaps the solution is best sought in state legislatures. In Wisconsin, tort reform is a matter of future legislation. However, Wisconsin has had a statute on the rolls for nearly ten years that was enacted to aid defendants to meritless suits—Wisconsin Statute §814.025 (1978), the frivolous law suit statute.

Wisconsin's frivolous lawsuit statute

814.025 ***Costs upon frivolous claims and counterclaims.*** (1) If an action or special proceeding commenced or continued by a plaintiff or a counterclaim, defense or cross complaint commenced, used or continued by a defendant is found, at any time during the proceedings or upon judgment, to be frivolous by the court, the court shall award to the successful party costs determined under s. 814.04 and reasonable attorney fees.

(2) The costs and fees awarded under sub.(1) may be assessed fully against either the party bringing the action, special proceeding, cross complaint, defense or counterclaim or the attorney representing the party or may be assessed so that the party and the attorney each pay a portion of the costs and fees.

(3) In order to find an action, special proceeding, counterclaim, defense or cross complaint to be frivolous under sub.(1), the court must find one or more of the following:

(a) The action, special proceeding, counterclaim, defense or cross complaint was commenced, used or continued in bad faith, solely for the purposes of harassing or maliciously injuring another.

(b) The party or the party's attorney knew, or should have known, that the action, special proceeding, counterclaim, defense or cross complaint was without any reasonable basis in law or equity and could not be supported by a good faith argument for an extension, modification or reversal of existing law.

By its wording, the frivolous lawsuit statute addresses meritless litigation, providing an immediate remedy for the defendant. Unlike counterclaims such as malicious prosecution which must be filed *after* the original suit has been terminated, this statutory relief is instead made by motion at any time during the original proceedings. This requirement was probably inserted to insure that the statute would not be used "after the fact"—if the defendant wins, the defendant decides to recover his or her costs in defending against the suit because he or she wins. Therefore, there is no need for the defendant to wait for the court to decide to dismiss the suit before reaching trial or until after successful termination of a trial on the merits, rather, the court can decide in a summary manner whether the suit was frivolous, and if so, if relief is due the defendant.

In addition, the statute sets up a showing that is less rigorous than the showing necessary for relief under any one of the tort doctrines previously discussed. Unlike malicious prosecution, the defendant need not prove malice or special damages. The statute creates a duty for the lawyer to not bring frivolous claims to court, avoiding the privity (duty) requirement of the negligence doctrine. This statute apparently answers the courts' call for legislative relief from meritless lawsuits. The question remains, is this relief effective?

From the few cases that are precedent (and therefore binding on lower courts) for the application of the frivolous lawsuit, much is left open concerning how well the statute works. The only standard that has so far emerged from higher courts is that when a motion is made against an attorney, the court determines whether the action is frivolous on an objective standard of what a reasonable attorney would have done under the same circumstances.[39] It is fairly certain who decides "reasonableness" in this case—not the jury, but the judge. Depending upon the judge's attitudes regarding protecting the legal profession from negligence suits in another guise, this reasonableness standard will probably vary greatly and give little guidance for future decisions. Most likely, the reasonable attorney standard will resemble "probable cause" as required in a malicious prosecution claim and that in itself is not encouraging. Without being too cynical about professional protectionism, if courts in other states were unwilling to recognize countersuits as a legitimate exercise of legal rights, there is reason to think that some courts in this state will hesitate before issuing a reasonable attorney standard that penalizes attorneys. Finally, just because the defendant wins on the merits does mean that the judge will grant relief under the frivolous lawsuit statute. And, as discussed above, the next consideration, whether the attorney acted reasonably, is probably not going to be easy for the defendant physician to prove.

Another question about the frivolous lawsuit statute is its usefulness in the Patient Compensation Panel context. Just as countersuits in general might not be recognized by courts as favorable terminations of judicial proceedings, a frivolous lawsuit motion might not be sustained during a panel hearing. Although the statute states that the motion can be made during an action or special proceeding, it has yet to be determined whether panel hearings are "special proceedings" as the term is used in the statute. Formal panel hearings are statutorily required to follow Wisconsin civil procedure, and a panel is therefore arguably a judicial body or at least must act like one. Moreover, the Patient's Compensation Panel is under the aegis of the Wisconsin Supreme Court. In this respect, the Panel should be able to entertain frivolous lawsuit motions. When the administrator of the Panel system was questioned about the statute's applicability, she responded that she had never encountered a frivolous lawsuit motion during a formal panel hearing but added that she thought the Panel would be empowered to entertain this motior for costs. Finally, she added that the motion seems to be most useful as a prehearing device to encourage settlement of meritless or weak malpractice claims. Perhaps the statute's informal use accounts for the lack of information about its function in a formal, that is, trial or hearing setting.

Summary

In summary, case law in other states demonstrates that the available tort remedies for defendants of meritless, malicious or frivolous malpractice suits are not generous. Although countersuit precedent in Wisconsin is sparse, namely, no malpractice countersuits have reached appellate court level yet, there is little reason to believe that Wisconsin courts will accept countersuits with any more enthusiasm than have courts in other states. There is a potential frivolous lawsuit remedy, Wis. Stat. §814.025, that provides relief from meritless lawsuits in terms of awarding statutory costs. However, in light of the limited relief afforded by the statute and the standard set down by the courts so far, the actual utility of the frivolous lawsuit statute is yet to be seen. A logical, although not necessarily comforting, conclusion could be that the real solution to the medical malpractice litigation situation is medical liability tort reform instituted through the state legislature.

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FOOTNOTES

1. *See,* e.g. *Thompson* v. *Beecham,* 72 Wis. 2d 356, 241 N.W.2d 163 (1976).
2. 186 Cal. Rptr. 545 (App. 1982).
3. 571 S.W.2d 567 (Tex. Civ. App. 1978).
4. 379 So.2d 412 (Fla. Dist. App. 1980).
5. 42 C.J.S. *Malicious Prosecution* §53 (1969).
6. *See,* e.g. *Spencer* v. *Burglass,* 337 So.2d 596, 599 (La. App. 1976).
7. *See,* e.g. *Weaver* v. *Superior Court,* 95 Cal. App. 3d 166, 156 Cal. Rptr. 745 (1975).
8. The "English Rule" is so named for Statute of Marlbridge enacted in British Parliament in 1267 which gave the prevailing defendant his or her costs and attorney fees in a summary proceeding at the conclusion of the original lawsuit. The defendant could get these damages only if he or she showed that he or she suffered some special injury apart from costs and expenses of defending the prior suit.

9. *See*, e.g. *Berlin* v. *Nathan*, 381 N.E.2d 1367, at 1371, *cert denied*, 444 U.S. 328 (1979).
10. 615 P.2d 957 (Nev. 1980).
11. See Levine, "I Beat a Malpractice Blackmailer," Med. Econ., Feb. 23, 1976, at 65 where the physician involved discusses this case.
12. DR 7-102 (A)(1) states:

    > In his representation of a client, a lawyer shall not: (1) File a suit, assert a position, conduct a defense, delay a trial, or take other action on behalf of his client when he knows or where it is obvious that such action would serve merely to harass or maliciously injure another.

    EC 7-10 provides:

    > The duty of a lawyer to represent his client with zeal does not militate against his concurrent obligation to treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm.
13. SCR 20.15(1) provides that a lawyer shall not accept employment on behalf of a person if the lawyer knows or it is obvious that the person wishes to bring legal action for the purposes of harassing or maliciously injuring any person. Similarly, SCR 20.15(2) forbids a lawyer from presenting a claim or defense in litigation that is not warranted under existing law, unless it can be supported by a good faith argument for an extension, modification, or reversal of existing law. See SCR 20.16(2), 20.36(1)(a).
14. *See*, e.g. *Brody* v. *Ruby*, 267 N.W.2d 902 (Iowa 1978), *Bickel* v. *Mackie*, 447 F. Supp. 1376 (N.D. Iowa 1978).
15. *supra*.
16. Most likely the court would point out the conflict of interests posed by the two code provisions—to represent the client zealously and to avoid meritless litigation but nonetheless resolve the conflict in favor of the duty to protect the client's interests. The Wisconsin State Bar through the Opinions of the State Bar Standing Committee on Professional Ethics issues an opinion on this conflict in Ethics Opinion E-83-4. In the end, this opinion suggests that where the conflict arises (which basically concerns the lawyer's duty to the client v. the lawyer's concern about liability under the frivolous lawsuit statute Wis. Stat. §814.025), the lawyer should consider the client's interests above his or her own. A court would use this form of argument to demonstate "good faith" or some other reason for exonerating the lawyer.
17. *Berlin* v. *Nathan, supra; Lyddon* v. *Shaw*, 56 Ill. App. 815, 372 N.E.2d 685 (1978); *Moiel* v. *Sandlin, supra*.
18. Black's Law Dictionary 137 (5th ed. 1979).
19. *See*, W. Prosser, Handbook of the Law of Torts, note 29 (4th ed. 1971).
20. 3 Wash. App. 139, 473 P.2d 202 (1970).
21. *See Tappan* v. *Ager*, 599 F.2d 376, 381-82 (10th Cir. 1979); *Wolfe* v. *Arroyo*, 543 S.W.2d 11, 13 (Tex. Civ. App. 1976).
22. Invasion of privacy differs from defamation in that injury in invasion of privacy is to peace of mind instead of reputation as in defamation.
23. *Wolfe* v. *Arroyo, supra*.
24. *See Morrison* v. *National Broadcasting Co.*, 24 Appl Div. 2d 284, 289, 266 N.Y.S.2d 406, 409, *rev'd on other grounds*, 227 N.E.2d 572 (1967). Also see *Belsky* v. *Lowenthal*, 405 N.Y.S.2d 62, 64 (1978). Prima facie tort was first enunciated by Mr. Justice Holmes in *Aikens* v. *Wisconsin*, 194 U.S. 194 (1904) in which he wrote that even lawful conduct can become unlawful if done maliciously.
25. 62 App. Div. 2d 979, 403 N.Y.S.2d 542 (1978).
26. *supra*.
27. *supra*, 405 N.Y.S.2d at 65.
28. 89 Misc. 2d 171, 391 N.Y.S.2d 61 (1977), *rev'd*, 61 App. Div. 2d 282, 402 N.Y.S.2d 250, *rev'd*, 46 N.Y.2d 778, 386 N.E.2d 821, 413 N.Y.S.2d 910 (1978).
29. *supra*, 402 N.Y.S.2d at 252.
30. *supra*, 386 N.E.2d at 822, 413 N.Y.S.2d at 911.
31. *supra*.
32. For example, the Illinois Constitution art. I, §12 states:

    > Every person shall find a certain remedy in the laws for all injuries and wrongs which he receives to his person, privacy, property or reputation. He shall obtain justice by law, fully, completely, and promptly.
33. *supra*, 381 N.E.2d at 1374 (1978).
34. *See O'Toole*, v. *Franklin*, 279 Or. 513, ____, 569 P.2d 561, 565 (1977).
35. *Berlin* v. *Nathan*, 381 N.E.2d 1367, 1375 (1978).
36. *id*, 381 N.E.2d at 1376.
37. HEW Medical Malpractice Report of the Secretary's Commission on Medical Malpractice (1973), note 7, at 10.
38. *See, Belsky* v. *Lowenthal, supra; Drago* v. *Buonagurio, supra* and *Berlin* v. *Nathan, supra*.
39. *Hessenuis* v. *Schmidt*, 102 Wis. 2d 697, 307 N.W.2d 232 (1981); *Sommers* v. *Carr*, 99 Wis. 2d 789, 299 N.W.2d 858 (1981).
40. Wis. Stat.§802.06(2)(f) (1981).
41. Wis. Stat.§802.08 (1975).

HELPING THE RETARDED, DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be mentally retarded.

A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. And a call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family in their county.

There should be local resources, psychological services, OT, etc available to complement the physician's examination. Also there are several clinics within the state that provide specialized evaluations for the persons who are mentally retarded and for persons with other developmental disabilities.

- **Child Development Center**
  Dr June Dobbs, Director, Child Development Center, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wisconsin 53201; (414) 931-4069

- **University Hospitals**
  Dr Charles Schoenwetter, H6 4th Floor, 600 Highland Ave, Madison, Wisconsin 53792; (608) 263-6421

- **Waisman Center on Mental Retardation**
  Pam Bright, Intake Coordinator, 1500 Highland Ave, Madison, Wisconsin 53706; (608) 263-5815

- **Comprehensive Evaluation Clinic for Multiple-Handicapped Children**
  Ms Marilyn Gratto, Miller-Dwan Hospital, 502 East 2nd Street, Duluth, Minnesota 55805; (218) 727-8762

Further information may be obtained from Merlen Kurth, Executive Director, Wisconsin Association for Retarded Citizens, Inc, 5522 University Ave, Madison, Wis 53705; (608) 231-3335. ■

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Medical liability—A physician's rights and responsibilities

THIS ARTICLE is intended to provide information about medical liability insurance and outline the rights and responsibilities of physicians and medical liability insurance carriers in the resolution of medical liability disputes.

COVERAGE AND POLICIES

Coverage

Medical liability insurance covers injuries arising out of the rendering or failure to render professional services. In addition to treatment rendered by the insured physician, liability insurance policies may include coverage of such things as: the acts of employees (performed within the scope of such employment) and service by the insured as a member of a formal accreditation, standards review, peer review, or similar professional board or committee of a hospital or professional society.

SMS RECOMMENDS: Check your policy for a complete description of coverage including what type of coverage you have if you assume liability by signing any type of medical care delivery contract which has a "hold harmless clause." Contact your insurance agent, carrier or SMS with any questions.

Types of policies

Two basic types of policies are available in Wisconsin—occurrence and claims-made.

Occurrence policies cover all claims resulting from professional services rendered during the term of the policy regardless of when the suit is initiated.

Claims-made policies cover claims only if: 1) the policy was in effect at the time the services were rendered, and 2) the policy was in effect at the time the suit was initiated.

SMS RECOMMENDS: Occurrence coverage.

Limits and amounts of coverage

Wisconsin law limits a physician's liability to $200,000 per occurrence and $600,000 per year. Therefore, these amounts are also the limits of liability insurance policies. The Patients Compensation Fund pays any portion of an award in excess of the $200,000/600,000 limits.

SMS RECOMMENDS: That all physicians carry $200,000/600,000 coverage so that the physician does not become personally liable for any portion of an award.

RIGHTS AND RESPONSIBILITIES

Provided the insured physician complies with the terms of the policy, the insurer is obligated to defend and pay damages on behalf of the insured in the event of a claim.

One of the most important responsibilities of the physician is to notify the insurance carrier on a timely basis of any claim made against the insured (or of any incident likely to result in a claim). Some policies set a given number of days within which the physician must notify the carrier, while others use such terms as: "as soon as practicable," "as soon as possible," "within a reasonable time," etc.

In the event of a claim or incident, the following information should be provided: name of insured, date and place of incident, circumstances of injury, name and address of injured party and any witnesses. The carrier will then notify you of any additional information which may be needed.

Physicians have both a right and responsibility to assist in the defense of a claim. The degree of participation granted to or required of the physician will vary from case to case and from one insurer to another. Likewise the desire to participate will vary among physicians.

SMS RECOMMENDS: That physicians become intimately involved in the development of the defense.

WHAT A PHYSICIAN CAN EXPECT

Outlined below is what SMS believes a physician can reasonably expect in his/her relationship with the carrier.

Competent defense counsel

The Wisconsin Health Care Liability Insurance Plan (WHCLIP) will, in most instances, honor physician requests that a particular defense attorney be appointed. While commercial carriers do not afford this

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opportunity, the physician can and should request a replacement if dissatisfied with the defense being provided.

Inasmuch as effective communication between the physician and attorney is essential to a successful defense, we see merit in providing the physician input into the selection of defense counsel. We also, however, recognize the expertise of carriers in this respect.

Regardless of how the defense attorney is selected it is critical that the physician and attorney work together to formulate a strong defense.

Although retained by the insurance carrier, the defense attorney owes his/her first allegiance to the insured physician. The physician is the client.

Participation in formulating the defense

The physician is entitled to:

- An initial conference to discuss the allegations and adjudication process;
- An explanation of the discovery process (through which the opposing party's case is explored) and a tentative timetable for completion of discovery and development of the defense;
- Review all depositions, learned treatises, etc. obtained by counsel;
- Participate in the selection of expert witnesses and exhibits;
- Copies of all correspondence between defense counsel and other interested parties (carrier, claimant, witnesses, etc.);
- An explanation of the technicalities of the Patients Compensation Panel hearing process;
- Question witnesses at the Panel hearing; and
- Full disclosure of the progress of all settlement negotiations.

We believe that most carriers and defense attorneys will welcome this type of participation. If, however, you feel you are not being allowed adequate input, discuss this with your assigned defense attorney. If your concerns are not allayed, contact your carrier. If still dissatisfied, contact SMS and we will attempt to resolve the problem.

OTHER CONSIDERATIONS

Physicians DO NOT have the right to "veto" settlements agreed upon by the carrier and claimant. Therefore, it is extremely important that you keep abreast of the development of your defense. A strong defense will lessen the carriers' inclination to settle, while a lax defense may indeed prompt a settlement (regardless of your guilt or innocence).

Even though you have no legal right to veto actions of the carrier, there is an ethical obligation upon the carrier and its attorney to provide you with an explanation of the carrier's decisions regarding settlements and appeals. You should request that your defense attorney advise you on these matters prior to their being finalized. Generally, the carrier will base such decisions on advice from defense counsel.

You are also entitled to prompt information about new developments in your case, final settlements or awards, appeals, and other aspects of the defense of your case. This again illustrates the importance of your continuing communication with the defense attorney and his or her regular communications with you. You can best affect defense and/or settlement decisions through your defense attorney.

SMS advises that you become familiar with the terms of your medical liability insurance policy, notify your carrier promptly in the event of a suit and assert your right to participate fully in your defense.

For more information contact the Medical Liability Committee of the Physicians Alliance Commission at the State Medical Society of Wisconsin, 330 East Lakeside Street, Madison, WI 53715. 1-800-362-9080, or (608) 257-6781. ■

Medical malpractice: A dilemma in the search for justice . . .

Robert J Flemma, MD, Milwaukee

HAVING BEEN INVITED to write an essay on medical malpractice for the *Law Review,* I vowed to avoid the opprobrious conduct currently in vogue with lawyers and physicians. The search for justice on behalf of injured patients deserves more than recriminations. It demands our best introspective thoughts, examining the causes and searching for solutions that will bring justice for patients, physicians, hospitals, attorneys, and society in general.

I. A BRIEF HISTORY

A. From Babylon to London

Throughout history, every civilized society has had medical healers, under some name or other. In earliest recorded time, these medical healers were perceived to have a special relationship with the gods; later, they professed to have some special knowledge which exceeded that of the lay person. For that reason the society would grant them special privileges in performing medical or surgical treatment upon others. Recognition of the potential for the harm or abuse resulting from unbridled privilege led to regulation of medicine in every society. The Code of Hammurabi from ancient Babylon was the first codified principle of law. Criminal law was guided by the principle of *lex talionis*—the eye for an eye, tooth for a tooth, concept. Medical practice was included under this principle, and carelessness and neglect were severely punished as a clumsy surgeon might lose both hands for a maiming operation.[1] The ancient Egyptians had specialists for various parts of the body, and if they wandered outside their special area of expertise or varied from the specifically prescribed modes of treatment, untoward results were punishable by death.

The historians of classical Greek culture have arrived at the conclusion that there were no legal mechanisms whereby those injured by a physician, or relatives of a deceased, could seek legal redress. One historian explained that the ultimate penalty for a physician was ill repute.[2] This remedy was of little solace to patients and their relatives and confuses today's legal scholars, because in that society even homicide was the subject of private suits. There was, however, a theoretical consideration of malpractice as arising from willfulness, negligence, or ignorance. Plato's thinking on the subject of ignorance as a cause of injury by physicians is apropos even today. He said ignorance falls into two categories: (1) simple ignorance causing minor errors; and (2) the double ignorance occurring when the physician is gripped not only by ignorance but also by a conceit of wisdom for things the physician knows nothing about.[3]

The Greeks furnished the great ideas, but the Romans translated them into practical use. The Romans distinguished between *dolus* (evil intent), *culpa* (including both negligence and incompetence), and *casus* (accident). *Dolus* fell under the intentional action of willful, intentional harm. *Culpa* and *casus* came under unintentional action.[4] The complex ambiguities of these concepts were a source of much legal ink for the Romans, as it is today. The Romans did recognize that there might be potential for harm without evil intent and established specific, albeit limited, provisions for seeking redress against the negligent or incompetent physician.

During the period 400 A.D. to 1300 A.D., the admixture of religion and medicine created the sense that disease was punishment for evil. Since there was virtually no rational medical treatment in this period, death and injury were considered the will of God and not to be questioned. This was a poor time for physicians and lawyers, as well as patients.

In fourteenth century England malpractice was closely interwoven with the theory of contract.[5] Physicians were commonly retained for set fees to provide care to wealthy personages or monastic groups, and suits arose when a physician would not travel to advise and examine them[6] or when a patient would stop paying the retainer fee.[7]

In England, the first classical malpractice case was recorded in 1375.[8] Although the surgeon was acquitted on a technicality, the judge stated that the surgeon indeed would have been liable for negligent treatment of a wound. By 1435 a second medical opinion was compulsory in London for "critical" cases.[9] Master surgeons and physicians were appointed by the mayor to conduct peer review of their profession and to be available for consultation prior to the treatment of these cases. They were also called to testify in recorded malpractice suits. Some surgeons began taking out malpractice "floater" policies on individual patients prior to treatment that might lead to death, serious injury, or accusations of malpractice.[10]

B. In the United States

The oldest recorded American medical malpractice litigation occurred in 1794 in Connecticut.[11] There were twenty-seven malpractice suits in the United States between 1794 and 1861 that were adjudicated as appeals in various state supreme courts and thus

Reprinted from the *Marquette Law Review,* Winter 1985, with permission. Doctor Flemma is Clinical Professor of Surgery, Medical College of Wisconsin, Milwaukee. The author wishes to acknowledge the assistance of Robert J Flemma Jr in the preparation of this article. Bound copies of this article together with a response by plaintiffs attorneys entitled "Medical Malpractice: Eliminating the Myths" are available from the *Marquette Law Review.* Please send 50¢ for each copy desired to: Marquette Law Review, 1103 West Wisconsin Ave, Milwaukee, WI 53233.

available for review.[12] Two-thirds of these suits involved injuries relating to orthopedic problems: fractures, amputations, and dislocations. Five involved obstetrics. This review is interesting because the malpractice suits then as now are a reflection of the predominant surgical practice of the time.

The concept of medical negligence began to evolve from the unintentional tort of negligence in this period. Courts upgraded physician responsibility for the care of their patients and expected doctors to practice up-to-date medicine. Physicians were alarmed at the increase in malpractice claims, and it is believed that some practitioners stopped their surgical practice because of the threat of malpractice.[13]

With the introduction of anesthesia in 1846, the practice of surgery expanded to operations within the abdominal cavity and was no longer primarily orthopedic and superficial-infection therapy. Over the next forty to eighty years, operations became standardized with predictable mortality and morbidity. By the 1920s hospitals began to provide more sophisticated laboratory equipment to analyze blood and urine, as science crept unobtrusively into patient care. In the latter half of the nineteenth century, malpractice claims continued, but the numbers are difficult to ascertain. What was evolving legally was the elevation of standards set by the courts.[14] Physicians were originally held to the standards of their type of medicine, that is, homeopathy, allopathy, and the like. But as medicine became more scientific, all practitioners were held to certain minimal local standards. *Pike v. Honsinger,*[15] an 1898 case in the New York Court of Appeals, stated the principles that with some modification provided standards and precedent for cases since then. Over the years, there was a change from local standards of care to national standards of care.

Between 1935 and 1955, there were 605 malpractice cases in the United States, an average of thirty-one cases per year.[16] In this period, California was the leader with almost seventeen percent of all the cases, followed by New York, Washington, Ohio, and North Carolina.[17] Fifty percent of cases were from eight states.[18] Between 1945 and 1949, the fewest number of cases occurred, and the largest judgment was $115,000.[19] This was the calm before the storm.

The advent of antibiotics in the 1940s and the scientific technological revolution left no area of the body unexplored, surgically or medically. Truly for the first time in the history of medicine, physicians had a greater chance of helping patients, rather than hurting them, with treatment. The science of medicine exploded, as laboratory tests and x-rays increased diagnostic ability and added greater accuracy and quantification of disease states. Physicians became more accountable for what they did, and their interpretation was more easily questioned by attorneys who could also review the same objective data and assess the physician's interpretation of results. The number of claims continued to rise, and by the 1970s physicians perceived the increase in the number and the size of claims as a threat that instigated job actions, strikes, and sit downs. It was called a crisis. However, a crisis can be a truly marvelous mechanism for the withdrawal or suspension of established rights and the acquisition and legitimization of new privileges. Indeed, there was a problem, as hospital malpractice premiums by 1976 were $1.2 billion per year, up from $61 million in 1960.[20] Physicians' premiums were skyrocketing, the number of claims was continually increasing, and this environment led to a "siege mentality." By 1975, the primary concern was the unavailability of liability insurance.

In 1973, the Department of Health, Education, and Welfare's Malpractice Commission strongly recommended pretrial screening panels as the primary method for speeding resolution of medical liability claims and eliminating nonmeritorious suits.[21] Many states reacted with legislation in about 1975. In Wisconsin, the legislature, in an attempt to get justice for physicians, patients, providers, and attorneys, set up the Patient's Compensation Panel and the Patient's Compensation Fund. The intent was to require that allegations of medical malpractice against a Wisconsin health care provider be heard by a panel prior to the filing of a circuit court action.[22] The Patient's Compensation Fund was created for the purpose of paying the portion of the settlement or award against the health care provider in excess of the insurance coverage required to be procured privately by all health care providers—$200,000 per claim and $600,000 in aggregate claims per year.[23] Has the panel system been helpful to all or has it been solely for the protection of providers—physicians and hospitals?

II. THE PROBLEM

From July 1, 1975 to June 30, 1984 a total of 2,012 malpractice claims were filed with the compensation panel in Wisconsin, more than fifty percent in the last three years.[24] Obviously, the incidence of claims has risen precipitously. Malpractice premiums for providers dropped initially, then rose dramatically as the frequency of claims and the size of awards and settlements grew.

Not only has this affected physicians, but these costs were passed on to patients leading to higher health care costs for every citizen of Wisconsin.[25] Today, professional liability insurance adds about $3 to the cost of a visit to a physician, $5 per day to the average hospital bill, and up to $300 to the cost of some births.[26] In Wisconsin, medical liability premiums totaled $27.9 million, and it is estimated that the accompanying defensive medicine—ordering all possible laboratory and x-ray tests in fear of reprisal—adds approximately $240 million to the Wisconsin health care bill.[27]

In this climate, malpractice attorneys are crying for the abolition of the compensation panel citing four main reasons.[28] They claim that the panel system: (1) causes unnecessary delay in final disposition of a claim; (2) is biased because there are two physicians, one attorney, and two lay persons on a formal panel;

(3) produces findings which have a "chilling effect" on any circuit court trial; and (4) protects repeat offender physicians about whom nothing is done. Let us now examine these arguments carefully.

Does the panel system cause unnecessary delays? The facts say no. Panel cases disposed of before a hearing have a median age of 362 days, while similar cases in circuit court require 532 days.[29] The median age of panel cases resolved through the hearing process is 391 days, while circuit court trials last 655 days.[30] Once opened, a case is usually resolved within one year. For informal panels reviewing smaller claims, eighty-five percent are settled in less than one year. For formal panels reviewing larger claims, sixty-four percent are disposed of in less than one year and an additional twenty-two percent are disposed of in less than one and one-half years. Before the panel system was instituted in 1975, it took an average of two years for a Wisconsin claim to be resolved; now it has been cut to less than one year.[31]

Indeed, any delays are due to lawyers and Wisconsin's three year statute of limitations. Indiana and Wisconsin have the same incidence of malpractice claims, yet Indiana attorneys get matters on file one year sooner because they have a two year statute of limitations.[32] And when a one year statute of limitations existed in Ohio, the claims also were filed on time.

Thus, the lawyer's argument does not withstand scrutiny, as indeed the panel system has effectively decreased the time to resolution for patients. The system has not been perfect, but with 1,152 claims filed in the last three years, the panel system was physically unable to meet its original goals. It is to the panel system's credit that it still resolves claims sooner than before its existence.

Is the panel system biased? Of the 1,512 closed claims, case disposition has been evenly divided between claimants and physicians. Fifty-six percent of all claimants received some compensation through the panel system, as either pre-hearing settlements or panel awards.[33] In fact, claimants in Wisconsin are more likely to be compensated than claimants in other states.[34] Nationally, in the years 1975 to 1978, claimants prevailed in jury trials fourteen percent of the time, while in Wisconsin panel hearings, claimants won thirty-one percent of the cases.[35] These data hardly support the bias claim. Claimants in Wisconsin utilizing the panel system are twice as successful as plaintiffs in jury trials.

Does the panel system produce a "chilling effect"? In the establishment of the panel system, the legislature allowed the findings of formal panels to be admitted in a subsequent circuit court trial. Lawyers feel this admission has a "chilling effect" on later trials.

In Wisconsin between 1975 and 1981, a review of ninety-five panel findings that were in favor of the physician revealed that twenty-three were ultimately settled with payment to the claimant.[36] Thus twenty-five percent of physician panel victories were ultimately settled with payment to the claimant when the insurance companies ignored the panel findings. When one remembers that Wisconsin panel verdicts are in favor of claimants more than twice as often as national court verdicts, providers have a greater right to concern than plaintiffs and their lawyers. And since less than ten percent of the panel cases were carried to a jury trial, it is difficult to find much merit in the "chilling effect" claim.[37]

Finally, are there many "repeat offenders" who are not disciplined? The answer is of great concern for physicians, who would be subsidizing these repeat offenders through premium payments to insurance companies and the panel system. There is no financial or professional incentive to protect repeat offenders. Medical malpractice falls under the broad category of unprofessional conduct. This is a problem because while conduct may be unprofessional it does not necessarily constitute medical malpractice. The way the system works is that complaints to the Medical Examining Board are investigated by an attorney; the board then prioritizes the complaints and decides the course of action. The board may receive allegations from: (1) the Department of Justice (Medicare fraud); (2) the Federal Drug Enforcement Administration (prescriptions); (3) Department of Health and Social Services (nursing homes); or (4) other physicians, pharmacies, and nurses. Only hospitals and the Patient's Compensation Panel are *required* to report to the Medical Examining Board. The compensation panel must report *negligent* providers to the board. A hospital must report the name of any staff member who loses hospital privileges for more than 30 days or resigns from the staff for 30 days or more. However, Wisconsin does not require the reporting of malpractice claims settled without panel awards. For example, from 1975 to 1980, 700 cases filed with panels were settled prior to a panel hearing;[38] thus no reports were issued to the Medical Examining Board. Further complicating the issue is the fact that insurance companies may settle a claim without the provider's approval since the settlement may be less than the anticipated expenses of preparing for a panel hearing. If providers and insurance companies fought all claims, there would be legal delays, a backlog of cases, and increased insurance premiums. These settlements indeed may allow a repeat offender to obfuscate the problem.

A fair solution to this has been proposed by the Medical Society: make all claims settled over $25,000 result in a report to the examining board.[39] This solution would not cause great paperwork for insurance companies. With computer technology, records could be easily kept, and paid claims could be categorized when reported to the board. They could distinguish between cases in which negligence appears to have occurred and those in which the issue of negligence was doubtful, but it was financially expedient to settle.

The Medical Examining Board's division of enforcement has less than five full-time investigators

and only two attorneys assigned to work with them. This staff must be increased if one expects two attorneys to review the over 400 claims filed each year. In this way, repeat offenders could be better identified, investigated, and disciplined. The board currently has difficulty even identifying the problem, much less dealing with it; in this area, the Medical Society and trial lawyers are in agreement. This does not, however, detract from the panel system's merits.

The Wisconsin Medical Society does have two recommendations that bear on this subject. First, it advocates that the Medical Examining Board contract with the Wisconsin Medical Society to investigate and review data on offenders.[40] The Medical Society already does this with Medicaid offenders, and there is a great financial incentive for all providers to identify offenders who repeatedly increase every physician's premiums. There would be no incentive for physicians to cover up, ignore, or subsidize substandard care of patients. And second, the Wisconsin Medical Society has also supported an increase in license fees if that increased revenue would be specifically allocated to pay trained board investigators. This proposal has been offered in two budget bills without being acted upon. The Medical Society has recognized the problem and has proposed some solutions but to little avail.

Although the panel system should not be abolished for the reasons cited by malpractice attorneys, it may still be improved. One improvement would be to utilize, on a rotating basis, retired or reserve judges and a retired physician. They would sit on panels involving the larger claims or those of repeat offenders, and their prestige would lend more authority to their findings. And to obviate any claim of conflict of interest, they should be paid by the state.

III. PATIENT CARE STANDARDS

It would be impossible to deal with all the implications of the present malpractice problem, but there are two scenarios that adversely affect patients, physicians, hospitals, and attorneys. Most reviews allude to a diminution of patient care standards, but do not demonstrate how this will occur. The following two scenarios provide some insight into the evolution of the bigger problem.

A. The Ob-Gyn Scenario

The practice of obstetrician-gynecologists (OB-Gyn's) is going to be the first area of patient care adversely affected. Throughout the country, sixty-six percent of Ob-Gyn's have been sued.[41] The frequency of claims has tripled since 1976, with the rate growing ten percent per year.[42] In Wisconsin, the current premiums for Ob-Gyn's are $18,600. There is in 1985 an anticipated rise of seventy-five percent on the current basic premium of $8,600 and a two hundred and fifty percent rise on the Patient's Compensation Fund premium of $10,000. If this occurs, the 1985 premium will rise to $15,000 for primary coverage and $25,000 for the fund premium for an estimated total of $40,000.

This malpractice insurance premium will have certain immediate effects on physician fees. Established Ob-Gyn's will pass these costs on to all young parents and those requiring gynecologic surgery. The fear of suits will again raise the cost of defensive medicine. Although this fear is felt to be exaggerated by many, one example may suffice. Neural-tube defects can be detected intra-utero by an expensive, somewhat risky, test that will have to be performed on all women despite the fact that these defects occur in only one in 1,000 newborns. Since Ob-Gyn's are being held liable if they do not suggest this test to an expectant mother, despite the low incidence of this defect, and allow her the choice of abortion, they will be forced to perform a multitude of tests not routinely done. The Ob-Gyn's cannot guarantee a perfect baby for all. This situation is unfair, impractical, and impossible, but it creates a specter in the Ob-Gyn's psyche that is not unreasonable.

In the long-term, Ob-Gyn's will drop out of obstetric practice, leaving lesser-trained physicians and midwives to perform almost all deliveries. Eighteen percent of Ob-Gyn's in Wisconsin have stopped accepting high-risk patients, such as diabetics, hypertensives, and women over thirty-five.[43] It is all well and good to say that they will be referred to high-risk units in university centers, but babies are not predictable; having to travel long distances will lead to more unattended deliveries. This risk carries an increased maternal mortality rate, and the inaccessibility of this service is going to lead to a greater maldistribution of medical resources. Fewer new physicians will be able to afford the insurance to start practice, and within ten years there will be fewer Ob-Gyn's available throughout the state. This will adversely affect the children and grandchildren of every person in Wisconsin.

B. Federal Scenario

Standards, rules, and regulations have usually been the domain of the individual states. However, as total health care costs have escalated, the federal government has been seeking ways to contain costs. The greatest concern is that looking at medical care through a financial tunnel may lead to health care as a commodity provided by the government at the lowest cost and not as a commitment to excellent care for all.

The establishment of DRG's is the first step, already in effect. A DRG is a form of reimbursement to hospitals by *disease related groups.* Diseases are categorized, and a prescribed number of hospital days are reimbursed for each category. It is hoped that this may work to eliminate inefficient practice patterns and thus save money. Economist Patricia Danzon feels that for DRG's to work "they must not be held to the customary norms of traditional fee-for-service medicine."[44] This willingness to subvert medical standards for economic purposes is frightening.

Danzon and Duke Law Professor Clark Havighurst raise the DRG question in relation to the standards required of health maintenance organizations (HMO's). An HMO contracts with a group of people to provide for all health care needs for a set cost per year. It theoretically provides incentives to physicians to keep patients out of hospitals and thus lowers health care costs. They further suggest that an HMO might contract to be bound not by a community standard of care, but by the standard of other HMO's in the country. Federal programs such as Medicare might also set up their own standards of care that would be based on economic considerations. Private insurers may offer a third more expensive plan and higher standards would be expected. It is conceivable that there could be two, three, or more standards of medical care based on the third party payor. Would economic restraint be translated into a different legal and medical standard of care? Havighurst casually said, "Only trial lawyers would have reason for complaint."[45] This is not true. The patients would have every reason to complain as would concerned physicians. The obvious answer to a multilevel standard of medical care has already been articulated: everyone would be subject to the federal standard which would be predicated on economics and politics, leading to the lowest common denominator being the standard. The federal government would have control of medical care and standards. However, there is little history that suggests it would function better than the post office or any other federal agency.

IV. MEDICAL SOCIETY PROPOSALS

The most critical area of change must be the expense of malpractice insurance, since premiums have increased the cost of health care and limited the availability of certain medical services.[46] The Wisconsin Medical Society has made several proposals designed to control this expense. First, raise the threshold to the Patient's Compensation Fund. Increasing the threshold (to $500,000 per claim, for example) would reduce the fund's liability, reduce duplication of efforts by primary carriers and the fund, and provide a stronger incentive for primary carriers to perform adequate loss prevention, claims management, and legal services. The original concept was that the fund would function as a catastrophic loss pool. However, from 1979 to 1983 the average dollar amount of claims paid by the fund has substantially exceeded this figure. In 1983, for example, 25 claims were paid at an average of $426,672 per claim.[47] It is obvious that awards greater than $200,000 have become the rule rather than the exception. The fund is threatened with insolvency, and this proposal would be a step toward the financial security of the fund.

Second, limit fund liability. Purchasing reinsurance could limit the amount the fund would pay on any given claim in a given year, and a statutory limit of $1,000,000 per claim as a fund responsibility would also limit liability.[48] This is in no way a limit on recovery or a cap on awards but simply a limit on the fund's liability. Physicians with need of more coverage than their primary insurance plus $1,000,000 in fund coverage could obtain it from the private market.

Third, structure payment of all fund awards. Currently awards in excess of $1,000,000 are paid in installments of $50,000 per year. This concept could, for example, be broadened so that all fund awards could be paid at $200,000 per year. Also, periodic payment of future damages—such as future medical expenses, modifications to residences, and purchase of specialized equipment—as incurred rather than as lump-sum payments would improve the management of fund assets.

Fourth, prohibit duplication of benefits and reduce awards by the amount available from collateral sources such as health and disability insurance, worker's compensation, and social security. The Rand Corporation's Institute for Civil Justice reported that a mandatory collateral offset is extremely effective in reducing the size of excessive jury verdicts and settlements.[49]

Fifth, limit awards for non-economic damages such as pain and suffering. Limits of $100,000, $200,000, and $500,000 have been suggested in other states. Data compiled from reports in the *Wisconsin Law Reporter* showed that non-economic awards exceeded economic awards.[50] Pain and suffering, being subjective emotions, can lend themselves to manipulation not only because of the jury's subjective assessment (sympathy) but also because of the attorney's skill and the claimant's appearance and demeanor. These factors have led to wide fluctuations in awards for the same type of injury.

Sixth, bifurcate the trial. Separate hearings on the liability and damage issues should be held. If liability is determined in the first hearing stage, the parties proceed with a hearing on damages. Plaintiffs' attorney Timothy Aiken stated that this proposal "makes sense. . .and would cut panel time at least in half."[51]

Seventh, restrict appeals of panel decisions. Measures must be taken to dissuade claimants who lose at the panel level from appealing cases to the circuit courts. Requiring the posting of bonds that are sufficient to cover the other party's legal costs has been suggested in other states. These are but a small percent of cases that are heard and should not be a great burden on over ninety percent of cases. The predominant reason for panel case dismissal is absence of merit or lack of prosecution.[52] From 1978 through 1981, eleven percent of all cases were dismissed.[53] This increased to thirty-one percent dismissals in all cases for 1983.[54] While not resulting in payment, congestion of the panel system delays resolution of meritorious claims and is expensive for the panel administrators and insurance carriers.

Eighth, implement loss prevention measures. Statewide data on claims must be gathered so that abuses of claims can be analyzed and prevention measures

focused appropriately. This data should be reviewed by a physician committee for loss prevention and peer review purposes.

Ninth, sanction "repeat" offenders. If peer review indicated multiple cases of negligence by a particular physician, sanctions such as surcharges, restricted coverage, or referral to the Medical Examining Board would be imposed.

Tenth, tighten the statute of limitations. Current statutes allow three years from the incident or one year from discovery of the injury, but never later than five years from the incident for adults; minors are bound by the adult statute or age ten, whichever is later. The American Medical Association has developed a model bill which allows two years from the incident or two years from discovery, but never more than four years from the incident for adults and the adult statute, or age ten, whichever is later, for minors.

Finally, limit attorney contingency fees. Several states have proposed sliding scales—for example, limit attorney fees to thirty-three percent of awards of up to $100,000, twenty-five percent of awards between $100,000 and $200,000, twenty percent of awards between $200,000 and $300,000, and fifteen percent of awards in excess of $300,000. This concept, which has been adopted by several states, ideally should be carried out by attorneys and not by state law. A group of reasonable attorneys who are most involved could set better guidelines. However, some prompt considerations of this subject by attorneys would be advisable. The federal government, as insurer of one-third of the population through federal programs, and the state see this limitation solely as a cost containment measure and not necessarily from an attorney's point of view. However, there is recognition of the fact that limiting the contingency fee may spur attorneys to seek higher damages than they would under the current system, and the move could well be counter-productive.

V. PHYSICIANS AND PATIENTS & LAWYERS AND CLIENTS

The barely comprehensible complexities of the malpractice problem have perversely led to oversimplification, suggesting it is just lawyers versus physicians. Unmentioned, but faintly recognized, are the facts that the patient is the victim and that society in general is affected through the malpractice problem's effect on the quality and availability of the modern advances of medicine. Thoughtful legislators recognize there is a problem, but the media's role in publicizing hostility and recriminations between physicians and lawyers has made it appear that legislators must choose sides. We all have to help solve the problem for the patient's sake. Physicians and lawyers have to see the relationship of their work to the whole fabric of culture and society. In doing this, we may elucidate rather than castigate, but it does require more introspection on all sides.

Dr. James Todd, while President of the Physician's Insurance Association of America, said "efforts directed toward tort reform and legislative relief must be reasonable and not self-serving. Malpractice is a medical problem not a legal one, and those injured as a result of negligence are entitled to fair and prompt compensation." Agreement with that point of view is shared by the vast preponderance of physicians. However, honest and competent physicians have the *right* to be free from spurious and frivolous claims that adversely affect their ability to care for patients. In the remainder of this essay, I would like to share personal introspections, from a physician's point of view, on the relationship of the physician to the patient, society, and attorneys as brought to light by the medical malpractice problem.

The patient, often neglected in this controversy, deserves some clearer definition. Pellegrino has pointed out that the word "patient" is derived from the Latin *patior* which means "to suffer" or "bear something."[55] It does not mean long-suffering. People become patients when they recognize that they lack the knowledge or skill to deal with illness. Their ability to function as "whole" persons is compromised, and they seek help from one who professes special skills and knowledge to deal with that loss of wholeness which is a disease state. It is an *unequal* relationship. Patients, by presenting themselves, acknowledge that they need help from someone who has more powerful tools and knowledge. This inequality is indeed recognized by patients as a diminution of their person, their ego, and their self-esteem, as well as a purely physical diminution. Patients are confronted with their own mortality, perhaps for the first time, and are no longer in control.

Patients present a problem because they have sought out the physician who professes to know how to help. Faith and confidence in that physician are an important prerequisite for healing to occur. Patients do not want to hear negatives or limitations. They want to be made whole and, because it works so often generally, expect that it will be just as easy individually. Medicine has been presented as "a miracle an hour with a few minutes out for commercials"—the Marcus Welby syndrome. This unequal relationship imposes great responsibility upon the physician who has professed to be skilled and knowledgeable with a commitment of those skills and knowledge to the benefit of others.

The word profession comes from the Latin verb *profitero* which means to make a public avowal or proclamation. While its earliest use was associated with vows to join a religious order, it later became a declaration of possession of skills and knowledge to be placed in the service of others. It is equally applicable to law and ministry. It has been bastardized today to mean a prestigious occupation; however, to return it to the older more meaningful level we must have "commitment," which means one places one's service to others above one's own self. This is a difficult goal to strive for. If not always attained, it

should be assiduously sought after as often as possible because the inequality between physician and patient is a potential source of patient resentment when profession of skills and knowledge are not manifest, or are performed carelessly.

In all efforts to explain the marked increase in malpractice claims nationally and locally, there are the usual stock answers depending on whether one talks with physicians, lawyers, patients, or legislators. I will not reiterate all of the reasons, but will try to reason from the definitions above to understand the motivation for the litigious avalanche.

I state categorically that the increase in claims does not represent a decrease in the quality of medicine locally or nationally. In both Wisconsin and the nation, medical practice is the highest quality in the world. Why, then, the paradox of increasing claims, and yet better medicine?

Let us reexamine malpractice under the three groupings identified by the Romans because they are still apropos. There is *dolus,* the use of medicine with evil intent and treachery. This conduct is a rare complaint and, when present, is dealt with by criminal law. Then there is *culpa,* which includes negligence and incompetence, and *casus,* which is accidental conduct. These two come under unintentional action, or now, action that results in a tort.

Definition is easy, but discerning the difference is much more ambiguous. The ambiguities result from the fact that medicine, despite fantastic progress, is not an exact science. Untoward or adverse results of medical treatment may occur without negligence or accident. Every proposed treatment or operation has certain negative side effects, an established incidence of complications and failures that occur regardless of how skillfully the treatment or operation is performed. It is the physicians' perception that lawyers do not understand this point and feel that negligence is behind every complication, side effect, or failure of therapy. It is all too easy for physicians to ascribe a lawyer's eagerness to sue for self-serving motives largely because of the contingency fee. While we realize that the contingency fee is the "key to the courthouse," we resent that as a result of the contingency fee the lawyer becomes a proprietor and partner in the suit. Lawyers have not diminished this perception by their media advertisements and portrayals of a "million dollar club." Physicians perceive this not as a pursuit of justice for the injured patient but as a technique that stimulates every patient to seek fortune through the malpractice suit.

The rise in the number of malpractice claims is not solely a creation of the lawyers' ingenious advertising. Medicine itself has contributed to the problem: as the scientific aspects of medicine exploded, the physician became identified as a medical scientist. Mastery of scientific knowledge and technology lead to many physicians apotheosizing themselves and their profession. This unfortunately is a double-edged sword. Lost was the humility of imprecise knowledge, and acquired was the hubris of technology. Physicians had been seduced into thinking that mastery of science and technology made them masters of the patient. Neo-Cartesian reductionism led medicine to believe that human beings are an electron transfer system gone awry, that can be righted by science if only well enough understood. Specialization and the acquisition of highly specialized knowledge was the logical aftermath of the scientific, technological breakthroughs depicted as daily events to the public by improved media communication systems. In the course of these technological successes, personal and hospital aggrandizement were not trivial events.

Lost in the hubris of the moment was the fact that physicians are unable to confer immortality. The patients, who by definition are not whole, were having expectations heightened, and specialization led to patients being treated skillfully for their individual parts. Specialist physicians became "part" doctors, and lost was the physician who could see patients as more complicated than the sum of the parts. Impersonality, inherent in specialization of medical care, while successful for many isolated problems, does not react well anymore to the majority of illnesses since illness does not usually occur in a vacuum. The whole of a person provides the setting in which illness occurs. The complete physician has to understand as much as possible about a whole patient to help the entire patient be made whole. There is a dichotomy between the true benefits of reductionist specialization and the needs of a whole patient.

This dichotomy can only be addressed when knowledge and skills provide physicians with an understanding of their limitations. The patients also must be made aware of medicine's limitations and not just its successes. Even the benefits of a simple aspirin must be weighed against its potential, but significant, harmful side effects. Surgeons must realize that the feasibility of an operation is not necessarily an indication for its performance. Physicians must differentiate between what a treatment does *to* a patient and what it does *for* a patient.

The physician's knowledge of beneficial and adverse effects of a treatment must be presented to the patient and be consonant with the patient's expectations from that treatment. The definition of consent is "to feel together" and "to feel with." Put in the context of physician hubris and unrealistic patient expectations, untoward, unexpected results lead to patient anger from unfulfilled expectations. This leads a disappointed patient to seek an attorney, turning the patient into a client.

Patients have been converted to clients by both professions. Physicians have been deficient in dealing with the whole patient and not recognizing and explaining the risks and limitations of therapy. By not understanding that medicine is not an exact science, lawyers seek to redress every untoward event by a lawsuit, even when no negligence is involved. I am not discussing motivation for claims when there has been negligent action, but those instances in which untoward results have occurred that could have been antic-

ipated in a certain percentage of patients. Physicians cannot be held to be guarantors of cure, nor should they present themselves as such.

The big problem lies not in the cost of liability insurance but in the consequences of the adversarial quality that relationships between physicians and lawyers have assumed. Society will protect itself from this destructive attitude. If confronted with no other choice, the federal government will intrude with cost containment measures that will lead to a lower quality of care for everyone. Before this occurs, both professions have to rid themselves of their entrepreneurial members who denigrate their respective professions. The time for self-serving rhetoric is past. For all parties concerned, come let us reason together for justice.

REFERENCES

1. *See* Reed, *Understanding Tort Law: The Historic Basis of Medical Legal Liability,* J. LFGAL MED., Oct. 1977, at 51.

2. See Amundsen, *The Liability of the Physician in Classical Greek Legal Theory and Practice,* J. HIST. MED., Apr. 1977, at 172, in which the author quoted from the text in translation of an anonymous treatise in the Hippocratic Corpus entitled *Law*.

3. *See* Amundsen, *supra* note 2, at 175. It is interesting that both Plato and Aristotle believed that physicians' actions could be best judged by other physicians.

4. *See id.*

5. For a discussion of the relationship between the medieval medical practitioner and early vestiges of the common law, see generally Post, *Doctor Versus Patient: Two Fourteenth-Century Lawsuits,* MED. HIST., July 1972, at 296-300.

6. Having been paid, the physicians would not make house calls.

7. These cases presage current health maintenance organizations (HMO) contracts by 600 years.

8. This case has been identified as Stratton v. Swanlond, Y.B. 48 Edw. 3, f. 6, pl. 11 (1375). *See generally* Chapman, *Stratton v. Swanlond: The Fourteenth Century Ancestor of the Law of Malpractice,* PHAROS, Fall 1982, at 20-24.

9. Cosman, *The Medieval Medical Third Party: Compulsory Consultation and Malpractice Insurance,* ANNALS OF PLASTIC SURGERY, Feb. 1982, at 155-58. Of particular interest is the author's discussion of a London ordinance in 1423 which required that a physician treating a critically ill patient consult a "master surgeon" on the case within three days of diagnosis. *See id.* at 157-58.

10. *See id.* at 161.

11. *See* Reed, *supra* note 1, at 53 (discussing Cross v. Guthrie, 2 Root 90 (Conn. 1794)). In *Cross,* a husband sued a physician for the death of his wife who was undergoing a mastectomy. He alleged unskillful, ignorant, and cruel treatment.

12. *See* Burns, *Malpractice Suits in American Medicine Before the Civil War,* BULL. HIST. MED., Jan.-Feb. 1969, at 42. One of the suits originated in a Racine, Wisconsin circuit court in 1853. *See id.* at 43-44 (citing Reynolds v. Graves, 3 Wis. 371 (1854)).

During this period, Abraham Lincoln had been a defendant's attorney in a malpractice suit. *See* Letter from Clark Heath to editor, NEW ENG. J. MED., Sept. 23, 1976, at 735-36. The letter refers to a quote attributed to Lincoln in defense of the accused surgeons: "Mr. Fleming, instead of bringing suit against these surgeons for not giving your bone proper attention, you should go on your knees and thank God and them that you have your leg." *Id.* at 736.

13. *See generally* J. ELWELL, A MEDICO-LEGAL TREATISE ON MALPRACTICE AND MEDICAL EVIDENCE, COMPRISING THE ELEMENTS OF MEDICAL JURISPRUDENCE (1860). Elwell published the first sytematic review of American malpractice claims and recognized that they had become a part of American medicine.

14. *See generally* Weigel, *Medical Malpractice in America's Middle Years,* TEX. REP. BIOLOGY MED., Spring 1974, at 191-205.

15. 155 N.Y. 201, 49 N.E. 760 (1898).

16. *See* Stetler, *The History of Reported Medical Professional Liability Cases,* 30 TEMP. L.Q. 366, 367 (1957).

17. *See id.* at 368.

18. *See id.* at 369.

19. *See id.* at 381.

20. *See* T. LOMBARDI, MEDICAL MALPRACTICE INSURANCE: A LEGISLATOR'S VIEW (1978). The author relied upon data presented in an interview of James L. Groves of the American Hospital Association before the New York State Senate Health Committee Staff on May 9, 1977.

21. *See* SECRETARY'S COMMISSION, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE REPORT ON MEDICAL MALPRACTICE, DHEW Pub. No. (05), at 73-78 (1973).

22. *See* DIRECTOR OF STATE COURTS OFFICE, A STATUS REPORT ON THE PATIENT'S COMPENSATION PANEL SYSTEM IN WISCONSIN: 1976-1981, June 1982, at 1.

23. This fund is paid for by the providers' contributions.

24. *See* WISCONSIN LEGISLATIVE COUNCIL STAFF, DATA RELATING TO MEDICAL MALPRACTICE, Informational Memorandum 84-25, Aug. 7, 1984, at 3 [hereinafter cited as LEGISLATIVE COUNCIL].

Wisconsin Compensation Panel Experience

	Claims Filed	Claims Paid	Average Paid/Claim
1978	145	4	$138,064
1980	262	10	$203,353
1982	413	18	$238,022
1983	376	25	$426,672
1984	451 (projected)	—	——

STATE MEDICAL SOCIETY OF WISCONSIN, REPORT TO THE LEGISLATIVE COUNCIL SPECIAL COMMITTEE ON MEDICAL MALPRACTICE, Sept. 4, 1984, at 3 [hereinafter cited as SMS REPORT]. SMS information was obtained from the Patient's Compensation Fund.

25. Certain groups, such as obstetricians, have even changed or ceased their practice. *See infra* text accompanying note 43.

26. *See* STATE MEDICAL SOCIETY OF WISCONSIN, STATEMENT TO LEGISLATIVE COUNCIL SPECIAL COMMITTEE ON MEDICAL MALPRACTICE, Sept. 4, 1984, at 1.

27. *See id.* at 2.

28. *See, e.g., The Medical Malpractice War,* NAT'L L.J., Aug. 27, 1984, at 1.

29. *See* SMS REPORT, *supra* note 24, at 21 (figures exclude Milwaukee County).

30. *See id.* (figures exclude Milwaukee County).

31. *See* MEDICAL PROTECTIVE COMPANY, PROFESSIONAL LIABILITY IN WISCONSIN, Sept. 4, 1984, at 4 (presented to the Wisconsin Legislative Council).

32. *See id.* at 4-5.

33. *See* PHYSICIAN'S ALLIANCE, STATE MEDICAL SOCIETY OF WISCONSIN, 1985-1986 LEGISLATIVE ISSUES 10 (1984).

34. *See* SMS REPORT, *supra* note 24, at 22 (citing study by the National Association of Insurance Commissioners).

35. *See id.* at 23.

36. *See id.*

37. *See id.* at 22.

38. *See* LEGISLATIVE COUNCIL, *supra* note 24, at 3.

39. *See* SMS REPORT, *supra* note 24, at 9.

40. *See id.* at 8-9.

41. Address by Elvoy Raines, *Management of Liability—Attracting Incidents,* to the Seminar on Gynecologic Surgery, St. Thomas, V.I., Feb. 16-19, 1984, at 1.

42. *Id.*

43. *See* SMS REPORT, *supra* note 24, at 6.

44. *See The Medical Malpractice War,* NAT'L L.J., Aug. 27, 1984, at 12 (testimony before Congress in July 1984).

45. *See id.*

46. *See supra* notes 24-27 and accompanying text.

47. *See* SMS REPORT, *supra* note 24, at 3.

48. St. Paul Fire & Marine Company stated that seventy-five percent of its insured physicians have policies with a limit of one million dollars. *See id.* at 12.

49. AMERICAN MEDICAL ASSOCIATION SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, PROFESSIONAL LIABILITY IN THE 80's, NOV. 1984, at 15.

50. *See* SMS REPORT, *supra* note 24, at 11. Information compiled from the *Wisconsin Law Reporter* between January 1, 1982 and June 23, 1984 indicated non-economic awards of $6,357,490 and economic awards of $5,143,110.

51. *See* WISCONSIN LEGISLATIVE COUNCIL, SPECIAL COMMITTEE ON MEDICAL MALPRACTICE: SUMMARY OF PROCEEDINGS, Sept. 4, 1984, at 11.

52. *See* SMS REPORT, *supra* note 24, at 21.

53. *See id.*

54. *See id.*

55. E. PELLEGRINO, HUMANISM AND THE PHYSICIAN 225 (1979). ■

Legal aspects of peer review

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MEDICAL PEER REVIEW is an indispensable part of modern medical practice. Peer review may be mandated or it may be voluntarily undertaken. It may be required by state licensure laws, federal laws, accreditation standards, or by individuals seeking to improve the quality of medical care in an institution. The review may be conducted within a particular institution, by an independent organization, by a medical society, or a variety of other individuals or groups. The review may focus on the appropriate utilization of services or facilities, analyze medical practices, recommend credentials decisions, or affect other aspects of patient care or medical services.

Courts have recognized the necessity of peer review activities. In *Bredice v. Doctors Hospital,* the court noted that the purpose of the meetings ". . . is the improvement, through self-analysis, of the efficiency of medical procedures and techniques. They are not a part of current patient care but are in the nature of retrospective review of the effectiveness of certain medical procedures. The value of these discussions and reviews in the education of doctors who participate, and the medical students who sit in, is undeniable . . . There is an overwhelming public interest in having those staff meetings held on a confidential basis so that the flow of ideas and advice continue unimpeded."[1]

For the physician involved in peer review activities, various questions arise: what is the legal liability exposure, will the proceedings and reports be accessible to medical negligence plaintiffs or others, and can members of a review committee be subpoenaed or deposed? No single answer applies to all of these questions in every state. The legal issues that arise involve both the common law and state statutes.

This article will discuss the most common theories of legal liability that arise and the various protections afforded to physicians involved in peer review activities.[2] The peer review protections applicable under Connecticut law will be discussed. [This section has been deleted and Wisconsin's peer review law has been added at the end of this article.]

Potential legal liability

Defamation

One of the most frequent allegations that arises from peer review activities involves defamation. Defamation is injury to a person's "reputation." One authority defines defamation as a communication that tends "to diminish the esteem, respect, goodwill, or confidence in which the plaintiff is held or to excite adverse, derogatory or unpleasant feelings against him."[3] To establish the legal cause of action for defamation, the plaintiff must establish that a written or oral communication was published to a third person by the defendant and that the third person became aware of its derogatory meaning.

Various defenses exist to a defamation allegation. Truth is an absolute defense. A conditional, or qualified, privilege exists with regard to communications made in good faith, without actual malice, when reasonable or probable grounds exist for believing the statements are true. Further, the communication must be one in which the author has an interest, or a public duty of a legal, judicial, political, moral, or social nature, and the communication must be made to a person with a corresponding duty.

The scope of this cause of action as applied to peer review activities is evident. The communications should be made in good faith and reasonable care should be taken to insure their truth. The information should be conveyed only to those persons who have an interest in receiving them, that is, persons who have the authority or responsibility to act on them. Peer review proceedings and opinions should not be repeated to persons not involved in the peer review process.

Courts have recognized the applicability of the qualified privilege doctrine to members of hospital medical staff and medical society committees responsible for evaluating the professional competence of colleagues. The courts tend to balance the obligation of the medical profession to assure the public of competent practitioners and the right of the physicians to maintain their reputations in the community. The court, in *Kinney v. Daniels,*[4] applied these principles. The Chief of the Medical Service reviewed the practice of a physician who had placed several patients on dialysis. During this review, the physician requested review reports from several members of the Internal Medicine department. The letter sent to the physician that questioned the propriety of the physician's activities was also sent to three other physicians who, in some manner, were responsible for privilege review and peer review in the hospital. The court found that the publication of the letter to these three physicians was within the common law, qualified privilege to defamation actions. The court stated that given the letter's substantial truth and limited publication in the context of health care peer review, the privilege applied.

Antitrust liability

To maintain an antitrust action, the plaintiff must satisfy a threshold requirement that the activities of the peer review committee affect interstate commerce

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within the meaning of the Sherman Act. In addition, the plaintiff would have to show that the physicians involved with the peer review combined or conspired to restrain trade or monopolized or attempted to monopolize within the meaning of the Sherman Act.[5] These requirements often are difficult to establish.

So long as the activities are within the legitimate scope of the peer review process and do not have an improper anticompetitive effect, antitrust liability should not exist. A recognized impermissible anticompetitive purpose is if a member of a peer review committee has an independent stake, usually economic, in achieving the object of a conspiracy.

Sokol v. University Hospital, Inc.,[6] discusses these antitrust arguments. In that case, the district court discussed whether the denial of staff privileges constituted an antitrust violation. The court said that the denial was ". . . an isolated instance of the restriction on one doctor's privileges, which may be analogized to a refusal to deal in commercial situations. This has not been held to violate the Sherman Act in the absence of an agreement, combination, or conspiracy. Whether the act complained of is an act of the corporation, the fact that the concurrence of a number of the personnel of a corporation is required to generate the corporate act does not satisfy the Sherman Act's requirement of an agreement, combination, or conspiracy."[7] Therefore, if the peer review activities are conducted properly, a court would have difficulty in establishing that a conspiracy existed.

Breach of a confidential communication

The relationship between physician and patient is extremely confidential. A physician who reveals a patient's confidential communications violates ethical principles unless the patient has authorized the release or it is required by law.[8]

The likelihood of a suit being brought because of a breach of confidentiality is remote. The review can be made by using a coding system to ensure anonymity of the patient, and the review is performed by physicians who are aware of the need for confidentiality. So long as the information is used for legitimate purposes no breach of confidentiality should arise.

The issue of whether an internal hospital committee may examine patient records was raised in *Kluge v. Lutheran Medical Center of St. Louis.*[9] The court recognized the hospital committee's right to review patient records and noted that the confidentiality of the patient's name can be assured in these proceedings.

Statutory privilege

All fifty states and the District of Columbia have enacted laws that restrict, to some degree, the civil liability of persons involved in medical peer review and the discovery and admissibility of peer review proceedings.[10] Some statutes provide complete protection of all activities and documents while others are not so comprehensive. At a minimum these statutes usually codify the conditional privilege that applies to defamation actions. The statutes vary in the scope of persons they cover. Some laws only cover physician members of the committees while others extend to agents and consultants of the committee and persons who provide information to or testify before the committee. Almost every statute provides immunity only to those persons who act without malice and in good faith. Some statutes require, in addition, that a reasonable effort must be made to ascertain the facts.

The discovery of peer review activities addresses conflicting goals of opening up the litigation process and insuring confidentiality. Without confidentiality, physicians would be more reluctant to serve on these committees and necessary professional self-evaluation would not occur. The value of self-evaluation has been recognized by courts and legislatures. Others argue that airing the truth about an incident is more valuable.

When evaluating whether certain communications are protected the wording of the statute is very important. For example, although the medical peer review proceedings are protected from discovery, the fact that they occurred may not be. Further, the statute, by its terms, may not prevent members of the medical review process from testifying if they have independent knowledge as to a particular physician's quality of practice that was not obtained through the peer review proceedings. Not all review documents may be protected. Incident reports that are not specifically mentioned in the statute probably are discoverable. Further, the laws generally cover only the medical review proceedings, not discussions about those proceedings after or outside of the meeting.

[The section on Connecticut statute has been deleted, and sections of the Wisconsin peer review law appear at the end of this article.]

Conclusion

General agreement exists that only the medical profession is qualified to evaluate the professional competence of physicians and the quality of medical care that they provide. Public policy favors protecting those activities of the profession designed to improve standards of professional competence and evaluate the quality of care available to the public. In every state, laws codify the protection, although no uniformity exists. Courts, in reaching their decisions, recognize these public policies and legislative goals. For these reasons, conducting objective peer review of the professional competence of colleagues does not appear to increase the liability exposure of physicians. However, the limits of these protections are defined by law and the physician who participates in peer review activities is advised to be aware of the scope of the applicable state law.

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2. A comprehensive discussion can be found in Peer Review: A Legal Update. American Medical Association, 1981.
3. W Prosser, Handbook of Tort Law, §111 (4th Ed 1971).
4. 574 F Supp 542 (SD W Va 1983).
5. 15 USC §§1, 2.
6. 402 F Supp 1029 (D Mass 1975).
7. Id. at 1030. See Smith v Northern Michigan Hospitals, 703 F 2d 942 (6th Cir 1983) and Pontius v Children's Hospital, 552 F Supp 1352 (WD Pa 1982) (in which the courts found that no independent stake or intracorporate conspiracy existed.)
8. Opinion 5.05, Confidentiality, Current Opinions of the Judicial Council of the American Medical Association, 1984. Some states have codified the confidentiality principles. Legal and ethical exceptions to confidentiality requirements are recognized.
9. 518 SW 2d 157 (Mo 1974).
10. See Peer Review: A Legal Update, supra, note 2. ■

Peer review in Wisconsin

WISCONSIN'S PEER REVIEW LAW is set forth in the two statutes reproduced below. The first statute, §146.37, does two things. First, it defines peer review programs for the purposes of the state law. Second, §146.37 grants civil immunity to those participating in good faith in peer review.

As a companion to §146.37 is §146.38 (see below), which was created by the same legislation, Chapter 187, Laws of 1975. This statute grants qualified confidentiality to information acquired in connection with peer review activities. Subsection (2) specifically states that records of peer review investigations, inquiries, proceedings and conclusions are not to be used in any civil action for personal injuries against the healthcare provider of facility under review. However, information, documents, or records used during review do not become immune from disclosure and discovery by virtue of their use during the peer review process. In other words, records created for and by the peer review committee receive immunity while other records, testimony, and documents otherwise accessible to the injured party remain so despite their use by the peer review committee.

The Wisconsin peer review law has been successfully defended from those trying to gain access to peer review information through claims that the laws are unconstitutional and therefore should be removed from the rolls. In one circuit court case, the judge upheld peer review's constitutionality, finding that the privileged status of peer review information rationally related to improving healthcare and minimizing healthcare costs. Until a higher court; *ie,* Appellate or Supreme Court, rules to the contrary, peer review's confidentiality provisions remain in good legal health.

146.37 Health care services review; civil immunity. **(1)** No person acting in good faith who participates in the review or evaluation of the services of healthcare providers or facilities or the charges for such services conducted in connection with any program organized and operated to help improve the quality of healthcare, to avoid improper utilization of the services of healthcare providers or facilities or to determine the reasonable charges for such services, or who participates in the hospital rate-setting activities under ch. 54 or s. 146.60, is liable for any civil damages as a result of any act or omission by such person in the course of such review or evaluation.

(2) In determining whether a member of the reviewing or evaluating organization has acted in good faith under sub. (1), the court shall consider whether such member has sought to prevent the healthcare provider or facility and its counsel from examining the documents and records used in the review or evaluation, from presenting witnesses, establishing pertinent facts and circumstances, questioning or refuting testimony and evidence, confronting and cross-examining adverse witnesses or from receiving a copy of the final report or recommendation of the reviewing organization.

(3) This section applies to any person acting in good faith who participates in the review or evaluation of the services of a psychiatrist, or facilities or charges for services of a psychiatrist, conducted in connection with any organization, association or program organized or operated to help improve the quality of psychiatric services, avoid improper utilization of psychiatric services or determine reasonable charges for psychiatric services. This immunity includes, but is not limited to, acts such as censuring, reprimanding or taking other disciplinary action against a psychiatrist for unethical or improper conduct.

History: 1975 c. 187; 1979 c. 221; 1981 c. 323; 1983 a. 27.

Person reviewing peer can be found to have acted in bad faith even if procedural rights under (2) were not denied, but whether procedural rights were denied is factor which must be considered in determination of "good faith." Qasem v. Kozarek, 716 F (2d) 1172 (1983).

146.38 Healthcare services review; confidentiality of information. **(1)** No person who participates in the review or evaluation of the services of healthcare providers or facilities or charges for such services may disclose any information acquired in connection with such review or evaluation except as provided in sub. (3).

(2) All organizations reviewing or evaluating the services of healthcare providers shall keep a record of their investigations, inquiries, proceedings and conclusions. No such record may be released to any person under s. 804.10(4) or otherwise except as provided in sub. (3). No such record may be used in any civil action for personal injuries against the healthcare provider or facility; however, information, documents or records presented during the review or evaluation may not be construed as immune from dis-

covery under s. 804.10(4) or use in any civil action merely because they were so presented. Any person who testifies during or participates in the review or evaluation may testify in any civil action as to matters within his or her knowledge, but may not testify as to information obtained through his or her participation in the review or evaluation, nor as to any conclusion of such review or evaluation.

(3) Information acquired in connection with the review and evaluation of healthcare services shall be disclosed and records of such review and evaluation shall be released, with the identity of any patient whose treatment is reviewed being withheld unless the patient has granted permission to disclose identity, in the following circumstances:

(a) To the healthcare provider or facility whose services are being reviewed or evaluated, upon the request of such provider or facility;

(b) To any person with the consent of the healthcare provider or facility whose services are being reviewed or evaluated;

(c) To the person requesting the review or evaluation, for use solely for the purpose of improving the quality of healthcare, avoiding the improper utilization of the services of healthcare providers and facilities, and determining the reasonable charges for such services;

(d) In a report in statistical form. The report may identify any provider or facility to which the statistics relate;

(e) With regard to any criminal matter, to a court of record, in accordance with chs. 885 to 895 and after issuance of a subpoena; and

(f) To the appropriate examining or licensing board or agency, when the organization conducting the review or evaluation determines that such action is advisable.

(4) Any person who discloses information or releases a record in violation of this section, other than through a good faith mistake, is civilly liable therefor to any person harmed by the disclosure or release.

History: 1975 c. 187; 1979 c. 89; 1983 a. 27. ■

"WATS" LINE FOR MEMBERS

As a service for its members, the State Medical Society of Wisconsin has a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

How to get health-related information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee the Todd Wehr Library (Medical College of Wisconsin). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given below. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Greater Midwest Regional Medical Library Network, which encompasses a six-state area and to the National Library of Medicine.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computer searches, including MEDLINE, can now be done at the resource libraries and at Columbia, St Joseph's, St Luke's St Mary's, St Michael's, Mt Sinai, St Francis hospitals and Good Samaritan Medical Center, Lutheran Campus in Milwaukee; Milwaukee County Medical Complex; Trinity Memorial Hospital, Cudahy; VA Hospital, Wood; St Elizabeth's Hospital, Appleton; Luther Hospital, Eau Claire; La Crosse Lutheran Hospital, La Crosse; Marshfield Clinic, Marshfield; Bellin Memorial Hospital, Green Bay; Waukesha Memorial Hospital, Waukesha; the Howard Young Medical Center, Woodruff; Holy Family Hospital, Manitowoc; Theda Clark Regional Medical Center, Neenah; Mercy Medical Center, Oshkosh; St Vincent's Hospital, Green Bay; Community Memorial Hospital, Menomonee Falls; Memorial Hospital at Oconomowoc, Oconomowoc; St Luke's Hospital, Racine; VA Hospital, Tomah; Wausau Hospital Center, Wausau; West Allis Memorial Hospital, West Allis; and Methodist and Madison General hospitals, St Mary's Hospital Medical Center, VA Hospital, and UW Clinical Sciences Center in Madison. If your local library cannot provide computer searches, it can forward any request to the most appropriate library in the network.

In most cases, the only charges will be for computer searches and for photocopies.

University of Wisconsin
Middleton Health
Sciences Library
1305 Linden Drive
Madison, Wis 53706
800-362-3020
ext 2-2376

Medical College of Wisconsin
Todd Wehr Library
Box 26509
Milwaukee, Wis 53226
414/257-8326 ■

Statewide Impaired Physician Program

THE STATEWIDE IMPAIRED Physician Program functions under the purview of the Commission on Mediation and Peer Review although its activities are managed by a six-member Managing Committee. The program follows an established protocol which guides the general handling of inquiries or concerns regarding identified impaired physicians. Available to members and nonmembers alike, the program continues to be one of education, identification, assessment, and compassionate intervention. The program refers patients to acceptable treatment facilities and monitors a two-year followup after initial therapy has been completed.

The Impaired Physician Program has achieved some success. A number of physicians have been encouraged by compassionate colleagues to enter structured rehabilitation programs. However, these few successes do not represent satisfaction of the needs of many other physicians continuing losing battles against alcohol or other chemical substances, or who suffer from emotional illness or senility.

Experience to date in Wisconsin and elsewhere provides convincing evidence that physician impairment is substantial, but its degree is unknown beyond what is identified and intervened. Most of the literature on the subject contends that from ten to fourteen percent of practicing physicians have difficulty with alcohol and drugs. Some research suggests that one out of every ten physicians during a lifetime will abuse alcohol in professional circumstances so as to be identified as "impaired."

Unfortunately, many people in a position to observe and identify impaired physicians do not know what to do when they perceive a specific problem, nor do they realize that help is available from organized programs. Furthermore, individuals such as medical staff members, hospital administrators, and others are reluctant to report a physician to an organized program. Their initial reaction is not to get involved, or to conclude that the problem can be handled by someone else in some other manner. This attitude often results in delayed intervention and treatment or in passive action which ultimately fails. Another concern is that those who might otherwise report an impaired physician may seek legal advice, only to be told by their lawyers to be noncommittal and to respond only to a subpoena. Such advice could be a deterrent to early intervention.

Current techniques of identification, intervention, assessment, treatment, and followup of impaired physicians are not well known in the medical community. Physicians are not generally adequately trained or skilled in identification, diagnosis, and treatment of patients with chemical dependency. The result is that few are able to respond adequately when they accept an impaired physician as a patient.

Since the beginning of the Impaired Physician Program, the State Medical Society has recognized the need to identify and publicize resources for treatment and appropriate followup of impaired physicians in Wisconsin. It learned that a more adequate system of outreach, treatment, and re-entry to medical practice needed to be designed, made available, and publicized. It noted that a physician recovering from impairment may very well bear associated financial stress and may be unable to sustain himself or his family without insurance, grants, loans, or other benevolent assistance. Techniques had to be improved for monitoring the degree to which impaired physicians respond to treatment and rehabilitation and return to medical practice.

The Society viewed the impaired physician as a medical family concern requiring close cooperation with the Society's Auxiliary which assists in identifying impairment and providing support for spouses and families. It also recognized that efforts should be made within premedical, medical, and residency training programs to provide resources for students and residents to deal with impairment.

In 1982, the State Medical Society Board of Directors approved development of an expanded statewide program for impaired physicians in recognition of these stated needs. The expanded program contains the following elements presently being implemented:

PHASE I: Education and Prevention

Target individuals and groups are being educated to an understanding of impairment among physicians as a result of chemical dependency. They are being informed of symptoms of impairment; the need for, and techniques of, early identification and prevention; the process of, and resources available for, identification, assessment, intervention, and treatment; and social, financial, legal, and other problems associated with impairment.

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

A. *Primary Target Groups being reached in education and prevention efforts are:*

1. Physicians: Meetings of hospital medical staffs, county medical societies, regional or statewide continuing medical education, and accredited seminars, *eg,* at the SMS Annual Meeting or specialty societies.
2. Hospital Personnel: Hospital administrators and medical directors, chiefs of medical staffs, hospital boards of trustees, directors of nursing and pharmacy and others, *eg,* anesthetists and technicians.
3. Pharmacists, Nurses, and Nursing Home Administrators: Lectures given through association meetings or in combination with physician and hospital personnel meetings.
4. Spouses and Families of Physicians: Educational material available at state and county medical society and auxiliary meetings.
5. Legal Profession: Efforts to convince lawyers, whose state association has its own impaired lawyers program, to encourage their physician clients to utilize organized medicine's voluntary impaired physician programs when perceived needs arise.

B. Teaching Staff for Educational and Prevention Phase

Teaching staff has presented educational and prevention programs to the various target groups. The team approach is employed and involves at least a physician and a physician recovering from alcohol or other chemical dependency.

C. Literature is being developed to assist in an understanding of the disease of chemical dependency and to explain resources for intervention, treatment, and followup.

PHASE II: Intervention and Treatment

To be successful, any impaired physician program structure must include the availability statewide of "physician interveners" who will be able to perform compassionate colleague-to-colleague contact with physicians who have been identified as impaired.

Approximately 25 physicians from throughout Wisconsin have been trained and are available to meet with and urge their impaired colleagues to leave medical practice and to enter suitable programs for evaluation and treatment. Interveners, sometimes known as confronters, act as teams. At least one intervener is either expert in, or has personal experience with, the impairment of concern. The initial approach of interveners with an impaired physician is always a compassionate encounter. The statewide program in Wisconsin has no interest in the punitive or coercive approach until all benevolent measures have been exhausted. An intervener's sole interest is the personal wellbeing of a colleague.

The Impaired Physician Program consistently has adhered to the policy that satisfactory recovery from chemical dependency can only be realized through a monitored two-year recovery period for each impaired physician. It considers the two-year "after hospitalization" to be a critical component in assuring continued recovery.

PHASE III: Benevolent Assistance

As it gains experience, the Statewide Impaired Physician Program finds that in addition to the burden of impairment, a number of physicians are unable financially to pay the cost of inpatient care. It is estimated that at least ten percent of Wisconsin impaired physicians either have no health insurance coverage or have coverage which is inadequate for the costs of inpatient care. Some have been ill for so long a period that their financial resources essentially have been depleted. About ten percent of the charges for rehabilitation of such physicians go unpaid. For twenty percent of impaired physicians, residence and treatment in "recovery homes" for an average of three months at a cost of $1,500 per month is essential for completion of the two-year recovery program. Furthermore, although adequately funded to date, no long-term provision has been established to allow realization of the program commitment to a two-year recovery program.

With the approval of the State Medical Society Board of Directors and the Board of Directors of the CES Foundation, the Impaired Physician Program established a Physicians Benevolent Assistance Fund. The Fund's $175,000 goal is to be accomplished through pledges to the CES Foundation earmarked for the Benevolent Assistance Fund and payable over a two-year period. The fund appeal among members of the State Medical Society and Wisconsin hospitals is designed to develop a fund of $150,000 for low-interest loans for physicians who potentially can repay them after completing the inpatient phase and returning to medical practice. A general purpose fund of $25,000 is intended to cover the costs of coordinating long-term support and monitoring physicians after the inpatient phase and on to completion of the two-year treatment program. The appeal program continues.

* * *

The State Medical Society program maintains formal linkage with the Wisconsin Medical Examining Board through the Coordinating Council on Physician Impairment. The Council consists of three physicians representing the State Medical Society and three members of the Medical Examining Board. The Council establishes guidelines for the Statewide Program and coordinates activities so that appropriate information is shared and Council action can be taken in the event a physician fails to respond to treatment or refuses to enter rehabilitation. The Council may refer a physician to the MEB in an instance where the health of the public may be jeopardized. The Council presents a desir-

able balance of concerns and interests between the voluntary assistance program of organized medicine and the state's statutory licensing and disciplinary body. Thus the Council is an appropriate step in the reporting process if necessary during attempts at physician rehabilitation where difficulty may be encountered.

Any responsible person concerned that a physician may suffer from an impairment may write to the Society or call 608/257-6781 in Madison or 1-800-362-9080 in Wisconsin. Strict confidentiality of all information is assured. Staff assigned to receive information will consult with the Managing Committee chairman for guidance and early action, but not before the information is evaluated for accuracy. When it is determined that a potential problem exists, an intervener team is recruited to meet with the involved physician. From that point the process evolves which should assist the physician to recognize the impairment and to accept a treatment plan leading to recovery and a return to a successful practice. ■

STATE MEDICAL SOCIETY

Mediation and Peer Review Services

PHYSICIANS ARE QUITE aware that medical care is a very personal matter between them and their patients. Medicine is not an exact science, and since each patient is different from all others and treatment approaches vary greatly from patient to patient, it is understandable that physicians and patients sometimes may not agree on what is proper care. At times misunderstandings arise about what the physician hopes to accomplish and what the patient expects. When this occurs, it is important that the patient first discuss any questions and concerns regarding medical treatment with his or her physician. In the event that such differences are not resolved at the doctor-patient level, the State Medical Society provides a means for resolving these differences.

The State Medical Society Commission on Mediation and Peer Review has the responsibility to receive, investigate, and resolve differences between physicians and patients or other complainants, and if necessary to take disciplinary action. The prime standard of judgment used by the Commission is what is good medical care. Many complaints and questions are accepted by State Medical Society staff and resolved by telephone. However, only a written complaint will be considered by the Commission through its protocol. If all affected parties reside within the boundaries of a single county medical society, that society will be asked whether it wishes to assume jurisdiction of the complaint. If it does, the complaint will be transferred to the county medical society for investigation and resolution.

A Protocol Manual was developed by the Commission on Mediation and Peer Review and approved by the Society's Board of Directors for conducting resolution of patient complaints, employing peer review mechanisms to test practice patterns of physicians, and responding to impaired physician inquiries or requests for action. It is reproduced below.

While reviewing this Protocol Manual, consider that it was designed to accomodate informal disposition of minor and uncomplicated complaints as well as complex and serious matters which raise questions including due process, patient or physician appeals, proposed disciplinary actions, and Board of Directors consideration of continuation of a physician's State Medical Society membership. Certain complaints received by the Commission on Mediation and Peer Review are resolved through case evaluation by a subcommittee of the Commission whose members provide reports and recommendations to the Chairman regarding the complaints. Frequently this subgroup reaches conclusions which are imparted in writing to both the subject physician and, as appropriate, to the complainant. In any event, all cases are reported to the Commission. Matters of more serious nature require application of the Protocol Manual as necessary.

* * *

COMMISSION ON MEDIATION AND PEER REVIEW

Protocol Manual

I. INTRODUCTION

Purpose

This Manual has been developed to guide and regulate the disciplinary activities of the State Medical Society of Wisconsin. It is designed to assure that these activities will be conducted fairly for all parties involved and will meet relevant legal standards of due process. In conducting its activities under this Manual the Commission is organized and shall be operated for the purpose of improving the quality of health care.

Factual Background

The Commission on Mediation and Peer Review is assigned the function of investigation, evaluation and decision of disciplinary matters for the State Medical Society of Wisconsin, subject to its Constitution and Bylaws and the policy control of its House of Delegates and Board of Directors. The procedures for conducting this disciplinary activity have been delegated to the Commission. In developing these protocols the Commission has considered Society discipline in relation to its other activities including mediation, peer review, and assistance to impaired physicians.

Jurisdiction

A. The Commission has jurisdiction over all complaints from whatever source on the basis of which any form of discipline may be imposed by the Society.

1. If the substance of a complaint under the jurisdiction of the Commission is also pending before any court, the Medical Examining Board or any other governmental agency, the Commission will suspend its disciplinary proceedings until the matter is resolved in the other form.
2. The Chairman of the Commission may, in his discretion and with the concurrence of the county medical society involved, cede jurisdiction over any disciplinary matter to a county medical society.
3. The Chairman of the Commission may, in his discretion, accept jurisdiction over any disciplinary matter initiated before a county medical society if requested to do so by any party to the proceeding and if the county medical society involved concurs.
4. The Society, through the Commission, may exercise original jurisdiction over complaints made to the Society.

B. The Commission has jurisdiction over all requests for peer evaluation of physicians and their services.

C. The Commission has jurisdiction over Society efforts to assist and rehabilitate impaired physicians.

D. In exercising its jurisdiction under these protocols the Commission shall follow, interpret and implement the policies of the State Medical Society of Wisconsin.

Commission Organization

A. For purposes of conducting its activities under this Manual, the Commission shall be organized to perform the following functions: (1) receipt and screening of complaints and requests, (2) mediation/investigation, (3) confrontation of impaired physicians, (4) case coordination, and (5) fair hearing.

B. The Chairman of the Commission may assign members of the Commission to the various functions, which assignments may be made on a term or case-by-case basis.

C. The Assignment of members of the Commission shall be made in a manner to assure that: (1) physicians who are subject to actions under the Commission's jurisdiction are treated fairly and decisions affecting them are made in an unbiased manner; (2) the Commission operates efficiently for the purposes for which it was created; and (3) the abilities and interests of Commission members are used effectively.

II. MEDIATION PROCEDURES

Complaints

A. All complaints on the basis of which discipline may be imposed by the Society shall be directed to the Chairman of the Commission or his designee for initial screening and acknowledgement.

1. Initial screening involves determination whether the complaint is one upon which disciplinary action may be taken and whether it is in a form to be acted upon by the Commission. At this stage complaints and inquiries which may lead to complaints may be informally handled and, if possible, resolved without further proceedings.
2. All complaints shall, if possible, be acknowledged indicating (a) whether the complaint is one upon which disciplinary action may be taken, (b), whether it is in form to be acted upon by the Commission, and (c) if not, what the complainant must do to put it in proper form. If the complaint is one upon which disciplinary action may be taken, a copy or abridgement of the relevant portions of the Society's Constitution, Bylaws and these protocols shall accompany the acknowledgement.

B. To be in form to be acted upon by the Commission, a complaint must:

1. Be in writing;
2. Be signed by the complainant;
3. Identify the complainant and the physician complained against by name and address;
4. State the nature and reasonable details of the complaint and identify, to the extent complainant is able to do so, other sources of information bearing on the complaint.
5. Include an authorization permitting the Commission or its designee to inspect and copy all medical and hospital records of complainant related to the subject of the complaint and waiving all privilege and confidentiality relating to such records and to any testimony or other statements related to the subject of the complaint.

C. After screening of a complaint, if it is one upon which disciplinary action may be taken and it is submitted in proper form to be acted upon, it shall be referred by the Chairman or his designee to one or more members of the Commission for mediation and investigation.

Mediation/Investigation

A. Those members of the Commission to whom the complaint is referred for mediation and investigation (the reviewers) shall review the complaint and any other Commission records related to the subject physician.

B. The reviewers or their agents shall contact the subject physician, notifying the subject physician of the fact that a complaint has been filed and providing such detail of the complaint as they deem appropriate. They shall also provide the subject physician with a copy of these protocols.

C. The reviewers shall arrange one or more meetings, as they deem necessary or advisable, with the subject physician.

1. The reviewers shall look into the details of the incidents upon which the complaint is based and determine the subject physician's position on these incidents.
2. The reviewers may expand their fact finding into other parts of the subject physician's practice than those related to the complaint. The subject physician shall be responsible to obtain all necessary authorizations for the reviewers to review such records as they may request and all necessary waivers for their use of the information obtained for the functions of the Commission.
3. As a condition to the mediation efforts of the reviewers and as an aspect of full cooperation by the subject physician, the subject physician shall

execute a written consent to mediation acknowledging that the reviewers are acting in good faith to help improve the quality of health care and waiving any right of action existing or later arising against the Society or anyone acting through it or on its behalf for good faith efforts to pursue the procedures established under these protocols.

4. In conducting their mediation efforts the reviewers may use or cooperate with other commissions or committees of the Society, county medical societies, the American Medical Association or any other public or private organization with the purpose of improving the quality of health care.

D. If it appears possible to resolve the issues of the complaint amicably between the complainant and the subject physician and this appears to be in the best interests of the public and the quality of health care, the reviewers may serve as mediators to effect such resolution.

1. In the event a complaint is resolved by mediation, the reviewers will submit a mediation report of their findings and the resolution of the matter to the Chairman of the Commission or his designee and action on the complaint shall be terminated.
2. The mediation report shall be maintained on a confidential basis in the records of the Commission.

E. If the complaint is not resolved by mediation, the reviewers shall submit an investigation report and recommendation for action to the Chairman or his designee.

1. The investigation report shall contain: (a) a synopsis of the complaint, (b) a summary of the reviewers' actions to investigate the complaint, (c) a statement of any investigation by reviewers beyond the scope of the complaint, (d) the reviewers' findings on the quality of health care provided by the subject physician in regard to the matter complained of and other aspects of the practice of the subject physician together with excerpts or copies of records or other matters discovered during the investigation which affect their findings, and (e) the reviewers' recommendations.
2. The reviewers may recommend: (a) dismissal of the complaint, (b) additional mediation to resolve the complaint or to correct deficiencies in the subject physician's practice, (c) proceeding with the Complaint before the Commission, or (d) such other action as the reviewers deem appropriate.
3. The Chairman or his designee, after consideration of the report and, if he deems it advisable, meeting with the reviewers, shall accept the reviewers' recommendations and proceed on the basis of them or pursue a different course of action, in which event he shall prepare and append to the investigation report a statement of his reasons for not accepting the recommendations. A copy of this statement shall be given to the reviewers.
4. The investigation report and any statements appended to it shall be maintained on a confidential basis in the records of the Commission.
5. Further action of the Commission on the matter shall be as determined by the Chairman or his designee. If further mediation is ordered, those members assigned to conduct it shall serve and report as reviewers under these protocols.

F. Failure of the subject physician to cooperate fully with the work of the reviewers may be considered cause for the imposition of discipline under these protocols.

Hearing

A. For each complaint with which the Commission proceeds, the Chairman or his designee shall name one member of the Commission as the Commission case coordinator.

1. The Commission case coordinator shall review the investigation report and recommendation and all other matters related to the complaint and investigation and may contact the complainant, the reviewers, the subject physician or such other persons as he deems necessary to prepare and present a case to a hearing panel. The Commission case coordinator may request from the Chairman such assistance as he may require for this purpose.
2. The Commission case coordinator shall prepare charges and specifications against the subject physician. These charges and specifications shall state the basis upon which discipline is sought and the alleged actions of the subject physician which may justify disciplinary action.
3. The Commission case coordinator shall be responsible for the preparation and presentation to the hearing panel of evidence, including witnesses, documents and physical evidence, relating to the imposition of discipline against the subject physician.

B. Within 15 days after advancement of a complaint for hearing, the Chairman or his designee shall appoint a hearing panel of not less than three members to hear the complaint.

1. None of the members appointed to the hearing panel shall have been involved in any way in the receipt, screening, reference, mediation or investigation of the particular complaint at any prior time nor shall any member be appointed to a hearing panel if there is any reason he would be unable to evaluate the matter fairly and objectively.
2. One of the members of the hearing panel shall be designated presiding officer of the panel by the Chairman or his designee.
3. The hearing panel shall be responsible for receipt and evaluation of evidence on the charges and specifications in each matter heard by it and for determination on the basis of the evidence received what discipline, if any, should be imposed by the Society against the subject physician.

C. The Commission case coordinator shall notify the subject physician by registered or certified mail with return receipt of the charges and specifications against him. This notice shall also include the time, date and place of the hearing on these charges and specifications as set by the presiding officer of the hearing panel. The hearing shall be set not less than 10 days nor more than 30 days after mailing of the notice, subject to rescheduling by agreement of the presiding officer, the Commission case coordinator and the subject physician.

D. The rules of procedure for a hearing under these protocols shall be:

1. The complainant and the subject physician shall have the right to be present at all times when the hearing panel is hearing testimony or receiving other evidence.
2. The complainant and the subject physician shall have the right to be represented at the hearing by a person of his choice, who may be an attorney.
3. The complainant and the subject physician shall have the right to present witnesses, documents and physical evidence relevant to the charges and specifications before the hearing panel.
4. The presiding officer may appoint a hearing officer to conduct the hearing procedure. If a hearing officer is appointed, he shall exercise the procedural discretions of the presiding officer under these protocols.
5. The hearing panel shall not be bound by rules of evidence applicable in courts of law but the presiding officer may limit evidence presented to that which is relevant and not unreasonably cumulative and may set time limits for the presentations of the Commission prosecutor and the subject physician so long as the limits set do not deprive the subject physician of a fair hearing of his case.
6. The order of hearing shall be: (a) the Commission case coordinator presenting evidence relating to the imposition of disciplinary actions; (b) the subject physician; (c) rebuttal by the Commission case coordinator. During rebuttal no new matters may be raised. Evidence may be presented by question and answer, in narrative form, or whatever manner the party chooses. There shall be no cross-examination but the hearing panel and hearing officer, if any, may ask questions of any witness. If the subject physician fails to appear at the hearing the Commission case coordinator shall present the evidence relating to the imposition of disciplinary action and this shall form the record upon which the hearing panel acts.
7. Parties may file written summaries or briefs within time limits set by the presiding officer.
8. All hearings may be recorded stenographically or electronically.
9. As to all other procedural matters the presiding officer shall establish such rules as will insure a fair and impartial hearing.

E. In those situations in which discipline is imposed for failure of the subject physician to pay dues or as a result of the subject physician's loss of his license to practice medicine, no mediation or investigation is necessary before prosecution. The Commission case coordinator shall have made a *prima facie* case by presenting a signed statement from the treasurer of the Society that the subject physician's dues are unpaid, or from a member or staff person of the Medical Examining Board that the subject physician is no longer licensed to practice medicine in Wisconsin, as appropriate.

F. The hearing panel shall meet in executive session to determine what discipline, if any, shall be imposed.

1. Discipline may include private or public reprimand, limitation, suspension or revocation of the subject physician's membership in the Society. The hearing panel may also recommend to the Society's Board of Directors that the matter be referred to the proper governmental agency for further action. This referral may be made only by act of the Board of Directors.
2. The hearing panel shall reduce its decision to writing stating: (a) the facts found by it, (b) that these facts do or do not support the imposition of disciplinary action, and (c) the discipline imposed or that no discipline is imposed. The decision shall be signed by a majority of the hearing panel and if any member of the hearing panel disagrees with the decision that member may present separate views which shall be appended to the decision.
3. A copy of the decision and separate views, if any, shall be sent registered or certified mail with return receipt to the complainant and the subject physician.

G. Within 15 days after the date of mailing of the decision, either the complainant or the subject physician may request in writing addressed to the Chairman that the matter be reheard.

1. Rehearing may be granted by the Chairman only on the grounds of material error by the hearing panel or new evidence which could not reasonably have been presented at the hearing. The request must be specific in stating and supporting the grounds asserted.
2. The rehearing, if granted, shall be held on 15 days' written notice to all parties who appeared at the hearing. It shall be limited to those matters stated as grounds for seeking rehearing.
3. A matter returned for rehearing shall be decided considering the additional evidence presented together with that originally presented. A decision as outlined in paragraph E., above, shall be issued and served.

H. The decision of the hearing panel shall stand as the act of the Society and shall be accepted and ratified by the Board of Directors unless it is appealed as provided in these protocols or the Board of Directors on its own motion determines the return of the matter to the Commission for further proceedings.

Appeal

A. A decision of a hearing panel may be appealed to the Board of Directors by either the complainant or the subject physician.

1. A notice of appeal shall be filed with the Secretary of the Society in writing within 15 days after (a) the final decision or (b) notice of denial of a request for rehearing is mailed to the party taking the appeal.
2. The notice of appeal must state: (a) the basis upon which it is taken, (b) that part or parts of the decision with which the appealing party disagrees, and (c) the appealing party's proposed modification of the decision.

B. An appeal under these protocols shall be set as a special order of business on the agenda of the Board of Directors not sooner than 15 days nor later than 90 days after the notice of appeal is filed with the Secretary unless all parties agree otherwise.

1. A summary of the matter shall be prepared by the presiding officer of the hearing panel for distribu-

tion as a confidential enclosure to the agenda. In the case of appeal from a county medical society decision, the summary shall be prepared by an officer of that society.

2. If the Secretary deems it necessary, all or part of the record of the hearing panel, including exhibits, documents and physical evidence, shall be made available to the directors in advance of or at the hearing of the appeal.

C. The appeal shall be heard before the Board of Directors in closed session.

1. The case for complainant shall be presented by the Commission case coordinator or his representative. The case for the subject physician shall be presented by the subject physician or his representative.
2. No new evidence may be presented on appeal nor will witnesses be heard. Presentations will be limited to argument of the issues as stated in the notice of appeal. Reference to evidence presented to the hearing panel may be made during such argument. The appealing party shall speak first and be given time for rebuttal. Written summaries or briefs may be submitted within time limits set by the Board of Directors.
3. The Chairman of the Board of Directors may set other rules of procedure, including reasonable time limitations, as he deems appropriate.

D. The Board of Directors may affirm, modify or reverse the decision appealed from or may refer the matter for further hearing and decision to a hearing panel with whatever instructions it deems appropriate.

E. The Board of Directors or Society committee so designated by the Board shall hear and decide appeals from disciplinary decisions of county medical societies using the same procedures as those set forth herein for decision of appeals from a hearing panel.

III. PEER REVIEW PROCEDURES

Requests

A. All requests for peer evaluation of physicians and their services shall be directed to the Chairman of the Commission or his designee for initial screening and acknowledgement.

1. Initial screening involves determination whether the evaluation procedure is one which the Commission is empowered to undertake and capable of undertaking and whether the requesting party is one for which the Commission may legally undertake the requested evaluation.
2. Compensation to the Society for the Commission's peer review activities shall be set by the Board of Directors.
3. The request shall contain such authorizations for the inspection, copying and use of records as the requesting party has relating to the subject matter of the request.
4. In acknowledging the request a copy of these protocols shall be supplied to the third party unless this has been done previously.

B. After screening of a request, if it is one which the Commission is empowered to undertake and capable of undertaking and the requesting party is one for which the Commission may legally undertake the requested evaluation, it shall be referred to one or more members of the Commission for evaluation.

Evaluation

A. Those members of the Commission to whom the request is referred for evaluation (the evaluators) shall review the request and any materials sent with it.

B. The evaluators or their agents shall contact the subject physician, notifying the subject physician of the fact a request has been received and providing such detail of the request as they deem appropriate. They shall also provide the subject physician a copy of these protocols.

C. The evaluators shall make as thorough an investigation as possible of the matters relating to the request so as to be able to report responsively to the requesting party.

1. The investigation may include meeting with the subject physician if the evaluators deem this necessary or advisable.
2. The evaluators shall seek to obtain, from the subject physician or otherwise, all authorizations for the inspection, copying and use of records necessary for them to investigate the matters thoroughly.
3. The subject physician shall be asked to execute a written consent to review acknowledging that the evaluators are acting in good faith to help improve the quality of health care and waiving any right of action existing or later arising against the Society or anyone acting on its behalf for good faith efforts to pursue the procedures established under these protocols. Refusal to execute this consent and waiver may be considered cause for the imposition of disciplinary action against the subject physician.
4. In conducting their review the evaluators may use or cooperate with other commissions or committees of the Society, county medical societies, the American Medical Association or any other public or private organization with the purpose of improving the quality of health care.

Report

A. Following their investigation the evaluators shall prepare a review report and submit this to the Chairman or his designee.

1. The review report shall be responsive only to the specific request of the third party and summarize the findings of the evaluators' investigation.
2. In addition, the evaluators may submit a supplemental report to the Chairman or his designee covering matters found in their investigation not bearing on a responsive reply to the request. The Chairman or his designee may, on the basis of the supplemental report, initiate mediation procedures or recommend that the Board of Directors refer the matter to an appropriate public or private organization.
3. Except as otherwise provided herein, the review report and any supplemental report shall be maintained on a confidential basis in the records of the Commission.

B. The Chairman or his designee shall read the review report and may, upon consultation with the evaluators or others, make modifications in it.

C. Once the review report is in final form, a copy shall be sent on a confidential basis to the third party who requested the peer evaluation and a copy shall be sent to the subject physician informing him that he may submit a statement objecting to or clarifying the review report. If any such statement is received a copy shall be promptly sent to the third party.

IV. IMPAIRED PHYSICIAN PROCEDURES

Requests

A. All requests for assistance to an impaired physician or notification of need for such assistance shall be directed to the Chairman of the Commission or his designee for initial screening and acknowledgement, if appropriate.

1. The term "impaired physician" includes physicians whose professional or personal well being or performance is adversely affected or threatened by abuse of alcohol or other chemical substances, or by reason of physical or mental illness or senility.
2. Initial screening involves verification of the facts underlying the request for assistance or notification.

B. After screening, if the situation involves an impaired physician, the Chairman shall designate a member of the Commission (the confronter) to "confront" the impaired physician in the company of a consultant. The consultant should be chosen on the basis of experience in the field of the subject physician's impairment, if possible.

Confrontation

A. The impaired physician shall be confronted compassionately by the confronter and the consultant with respect to the impairment and advised of the concerns of colleagues, family and others.

B. The confronter shall discuss the impairment with the subject physician and urge acceptance of appropriate recommendations of assistance. The confronters shall not provide any form of therapy, but rather recommend available types of therapy and identify and suggest rehabilitation facilities through which therapy is available.

C. Confrontation on more than one occasion by different teams of confronters and consultant may be necessary.

D. Assuming the subject physician accepts and enters a course of rehabilitation or therapy, liaison shall be maintained with the impaired physician and seek to obtain reports concerning his progress rather than the details of therapy.

E. All records, notes and reports related to the confrontation of impaired physicians shall be maintained on a confidential basis in the records of the Commission.

Referral

A. In the event the subject physician refuses to accept confrontation, declines to enter or continue a recommended course of treatment, or abandons treatment prematurely, the Chairman of the Commission or his designee shall on consultation with the chairman of the Board of Directors refer the matter to the Medical Examining Board or other appropriate agency if the subject physician poses a potential health hazard to the public.

B. If no such potential health hazard exists, the Chairman of the Commission may recommend that the Board of Directors refer the matter. The Board of Directors shall not refer the subject physician to the Medical Examining Board until it has advised the subject physician in writing of its intent to refer, the reason for referral, and has allowed 15 days for an appeal of the proposed action. ■

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STATE MEDICAL SOCIETY OF WISCONSIN
SMS SERVICES INC.
A SUBSIDIARY

- Claim form approved by DHSS and EDS Federal for Wisconsin Medical Assistance Program (WMAP) claims.
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- Form costs one third less than its national competitor.
- Available in two-part snapout and one- or two-part continuous form.
- Forms will be shipped to you within 48 hours after order received.

Place your order with SMS Services, Inc, 330 East Lakeside Street, PO Box 1109, Madison, Wisconsin 53701; or phone (608) 257-6781 or toll-free in Wisconsin (800) 362-9080.

WISCONSIN ADOPTION AGENCIES

Licensed Voluntary Agencies

Bethany Christian Services, W255 N499 Grandview, Waukesha 53187

Catholic Social Services—Diocese of Green Bay, 1825 Riverside Dr, PO Box 38, Green Bay 54305

Catholic Charities, Inc,—Diocese of LaCrosse, 128 South 6th St, PO Box 266, LaCrosse 54601

Catholic Social Services—Diocese of Madison, 2702 International Lane, Madison 53704

Catholic Social Services of the Archdiocese of Milwaukee, Inc, 2021 N 60th St, Milwaukee 53208

Children's Service Society of Wisconsin, 610 North Jackson St, Milwaukee 53202

Lutheran Children's Friend Society, 8138 Harwood Ave, PO Box 13367, Wauwatosa 53213

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Blvd, Milwaukee 53208

Pauquette Children's Service, 304 West Cook St, 53901

Seven Sorrows of Our Sorrowful Mother Infants' Home, Rt #1, Box 905, Necedah 54646

Wisconsin Lutheran Child and Family Service, 6800 North 76th St, Milwaukee 53223

Public Agencies

Division of Community Services (Regional Offices) (See page 152 for list of Regional Offices.)

Milwaukee County Department of Social Services, Child Welfare Division, 1220 West Vliet St, Milwaukee 53205

Maternity Homes

Lutheran Maternity Home, 1910 South Avenue, LaCrosse 54601

Rosalie Manor, 19305 West North Ave, Brookfield 53005

* * *

Agencies licensed to make adoptive home studies and to contract with other agencies to make placements but not licensed to accept guardianship.

The Human Element, Inc, 2701 North 56th St, Milwaukee 53210

Hope International Family Services, Inc, 421 S Main St, Stillwater, MN 55082

WISCONSIN POISON CONTROL PROGRAM NETWORK

It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week. Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report certain poison incidents to the Division of Health.
- conduct education and prevention activities in the community.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/931-4114

Poison Center—Madison Area
University Hospitals
600 Highland Avenue
Madison, WI 53792
Tel 608/262-3702

The three satellite centers are:

Eau Claire Poison Center
Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

Green Bay Poison Center
St Vincent Hospital
835 So Van Buren St
Green Bay, WI 54305
Tel 414/433-8100

LaCrosse Poison Center
St Francis Hospital
709 South 10th Street
LaCrosse, WI 54601
Tel 608/784-3971

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the

WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH

PO Box 309 **Madison, Wis 53701**

Wisconsin's fee splitting statute

WISCONSIN'S LAW prohibiting fee splitting appears as a part of the Medical Practices Act, Wisconsin Statute Chapter 448. The original fee splitting law was enacted in 1913. At the time it was passed, the law's objective was to prohibit physicians and surgeons in the larger cities from paying fees or commissions to the country physicians and surgeons for inducing or advising patients to submit to operations or treatments by the city physicians and surgeons. Despite subsequent changes in 1959, 1973, 1975 and 1977 in numbering, organization, and the inclusion of additional provisions, the law's basic prohibition, to prevent physicians from receiving referral fees and commissions from other healthcare providers, has remained constant.

Another important feature of the fee splitting statute is its definition of physician employment and consultation contracts with hospital and medical education and research organizations. Vital to this definition of employment and consultation contracts is the manner in which contracts are authorized through both the institution and its medical staff.

In conjunction with the statutory prohibition against fee splitting practices set out in §448.08, Chapter 448 of the Wisconsin Statutes includes a penalty section, §448.09. Under the penalty section, violations as described in 448.08 are punishable by fines not to exceed $10,000 or imprisonment not to exceed nine months or both. Because criminal penalties are imposed, section 448.08 must be strictly construed, that is to say, the fee splitting definitions must be read for what they state and not for what they could mean. With this guideline in mind, what follows is a provision-by-provision look at the fee splitting statute with interpretative and explanatory comments.

Wisconsin Statutes, section 448.08 (1977)

(1) **Fee Splitting.** Except as otherwise provided in this section, no person licensed or certified under this chapter may give or receive directly or indirectly to or from any person, firm or corporation any fee, commission or rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a licensee in a professional capacity, or for any professional services not actually rendered personally or at his or her direction.

The first section of the statute prohibits two things. First, it prohibits a licensee under chapter 448 from receiving any fee for sending, referring or otherwise inducing a person to communicate with another licensee. Second, the statute prohibits any licensee under the chapter from receiving any fee "for any professional services not actually rendered personally or at his or her direction." Each reference the statute makes to "licensee" means *all* licensees under chapter 448, namely, (1) physical therapists, (2) physicians, and (3) podiatrists.

More specifically, the statute prohibits a physician from taking any fee or commission from another service provider, even if the provider is not licensed under chapter 448 for any service not actually personally rendered by the physician or at the physician's direction. "Service provider" refers to hospitals, laboratories, clinics as well as allied healthcare providers whether licensed by state law or not. A physician violating this provision will be subject to the penalties listed in section 448.09 although the service provider, if not licensed under chapter 448, will not be subject to these or other criminal penalties.

The statute *does not* prohibit a physician from participating with or directing a licensee, such as a physical therapist, to render treatment to the physician's patient where both the physical therapist and physician receive compensation for service rendered. (See Opinions of the Attorney General, vol. 71, April 15, 1982.) In this instance where the physician utilizes the services of another licensed provider, the separate billing requirement of subsection (2) must be followed.

(2) **Separate Billing Required.** Any person licensed under this chapter who renders any medical or surgical service or assistance whatever, or gives any medical, surgical or any similar advice or assistance whatever to any patient, physician or corporation, or to any other institution or organization of any kind, including a hospital, for which a charge is made to such patient receiving such service, advice or assistances, shall, except as authorized by Title 18 or Title 19 of the federal social security act, render an individual statement or account of the charges therefor directly to such patient, distinct and separate from any statement or account by any physician or other person, who has rendered or who may render any medical, surgical or any similar advice or assistance to such patient, physician, corporation, or to any other institution or organization of any kind, including a hospital.

This section prohibits fee splitting by requiring that each healthcare provider licensed under this chapter who renders service to a patient list the charge for service separately and distinctly on the bill. Separate billing is also required of a licensee who renders medical services or gives advice or assistance to a corporation, or any other institution or organization of any kind, including a hospital.

This section does not prohibit a physician from billing a patient for the services of a licensee, such as a physical therapist, who is employed by the physician's service corporation organized under Wisconsin Statute section 108.99 so long as the bill reflects the separate charges. The reason why this situation is not fee splitting is that the licensee's bill alone could not include the cost of his or her employment to the service corporation, *ie* salary, fringe benefits, and operating expenses. The physician is not receiving a referral fee or commission from the services rendered by the licensee in this case, rather, the service corpora-

tion is charging the patient for the overhead involved in providing the licensee's services.

It would be a violation of this section if the physician billed a patient for services rendered if the physical therapist's services are included in the total charge rather than stated separately and distinctly as required in the statute. Without the explicit listing of services, the implication could be that the physician is exacting a fee for providing the physical therapist's services. This rule applies whether the services were rendered in a clinic, hospital, nursing home or other institutional setting unless federal law provides otherwise.

(3) **Billing For Tests Performed By The State Laboratory Of Hygiene.** A person other than a state or local government agency who charges a patient, other person or 3rd party payer for services performed by the state laboratory of hygiene shall identify the actual amount charged by the state laboratory of hygiene and shall restrict charges for those services to that amount.

This section addresses a specific circumstance under which no referral fee can be added to a bill for services—when laboratory services are performed by the State Laboratory of Hygiene. The licensee or his or her service corporation should be able to charge the patient or payer for reasonable costs of collecting, preparing and transporting specimens analyzed by the State Laboratory of Hygiene so long as this charge is clearly identified on the bill for service.

In addition to this prohibition under state law, the AMA Judicial Council addresses laboratory charges in the *Current Opinions.* In this set of opinions, the AMA Judicial Council states that when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the actual charges for laboratory services, including the name of the laboratory, as well as any separate charges for his or her own professional services. As does subsection (3), the AMA Judicial Council opinion underscores the principle that any compensation paid to or *presumed by law to have been paid to* the physician by a provider for referring business to the provider is illegal and unethical, whether that provider is a clinic, laboratory, hospital, another licensed or nonlicensed provider.

One question that arises from this discussion of laboratory referrals is what happens when a physician has ownership interest in a laboratory through, for example, a general corporation rather than a service corporation, and refers patient tests to this laboratory from which he or she receives profits? This question was posed to the Wisconsin Attorney General's Office which enforces this and other state statutes. The informal answer given is that so long as the laboratory charges are listed separately on the patient's bill for medical services, the physician would not be in violation of the fee splitting statute. In this instance, the purpose of the fee splitting prohibition is not involved although the physician does indirectly receive compensation for referring business to this nonservice corporation business entity. The key to determining when the fee splitting prohibition applies goes to the original intent of the law—preventing kickbacks and referral fees between healthcare providers.

(4) **Professional Partnerships And Corporations Permitted.** Notwithstanding any other provision in this section, it is lawful for 2 or more physicians, 2 or more podiatrists or 2 or more physical therapists, who have entered into a bona fide partnership for the practice of medicine, podiatry or physical therapy, to render a single bill for such services in the name of such partnership; and it also is lawful for a service corporation of physicians, podiatrists or physical therapists to render a single bill for such services in the name of the corporation; provided that each individual physician, podiatrist or physical therapist rendering services so billed for shall be individually identified as having rendered such services.

As mentioned previously, the statute recognizes the instance where the services provided to a patient involve a service corporation duly formed under Wisconsin Statute section 180.99. In this case, fee splitting is not presumed when the service corporation bills the patient for services rendered by an employe and the employe is listed as having rendered this service on the bill. (For information on service corporations under Wisconsin law, see SMS brochure "Guide to the Service Corporation Law".)

The statute also provides an exception for bona fide partnerships between licensees of the same category ("2 or more podiatrists . . ."). This means that there must be a genuine, provable contract between the practitioners. A "good faith" partnership does not include one created for some single occasion or circumstance, or an artificial arrangement between two or more practitioners set up for the primary purpose of avoiding the statutory requirement of separate billing in subsection (2). Filing partnership income tax returns would ordinarily indicate the organization's good faith.

The AMA Judicial Council discusses dividing income among members of a group practice in its *1984 Opinions.* In this section, the AMA Judicial Council states that the division of income among members of a group, practicing jointly or in a partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his or her other services and contributions to the group. This activity is apparently permissible under the statutes if the group is a bona fide partnership or a professional service corporation and if the income received was billed according to this subsection, that is, the bill showed which provider supplied the service to the patient.

(5) **Contract Exceptions; Terms.** Notwithstanding any other provision in this section, when a hospital and its medical staff or a medical education and research organization and its medical staff consider that it is in the public interest, a physician may contract with the hospital or organization as an employe or to provide consultation services for attending physicians as provided in this section.

Subsection (5) introduces the situation in which the next statutory exception to fee splitting may occur: when a physician is employed by a hospital or a medical and educational research organization. By the statute's language, this contract between the physician and the institution or hospital may either be for employment or consultation services. The reference to "its medical staff" refers to those physicians and surgeons having staff privileges in the institution, even though the medical staff might not be formally organized as might be the case in a limited number of institutions. Finally, the statute requires that the institution and the medical staff find that physician contracting is "in the public interest." This requirement means that there is a finding as such by the governing body of the hospital, *and* by a similar finding by the medical staff. To avoid misunderstanding, this finding should be incorporated in the medical staff and hospital records.

The purpose of this subsection is to give *continuing authority* to *both* the medical staff *and* the governing body of the hospital to rescind its earlier finding, to modify it in some respects, or to elaborate it in other respects. In other words, the decision once made is not irrevocable.

> (a) Contracts under this subsection shall: 1. Require the physician to be a member of or acceptable to and subject to the approval of the medical staff of the hospital or medical education and research organization. 2. Permit the physician to exercise professional judgment without supervision or interference by the hospital or medical education and research organization. 3. Establish the remuneration of the physician.

This provision outlines what a contract between a physician and hospital or medical education and research organization must establish under the fee splitting exception. The first requirement emphasizes the previously mentioned concept that the medical staff must approve of the physician contracting situation as well as the physician with whom the institution contracts. It is not enough that the physician with whom the institution wishes to contract be a member of the medical staff, having first passed the screening involved in the application and credentialing process required for medical staff membership. The statute clearly states that the contracting physician employe or consultant be a member of or acceptable to the medical staff *and* subject to the approval of the medical staff of the contracting institution. Therefore, the statute gives *the medical staff co-equal powers with the institutional board in deciding whether it is in the public interest at all to contract with a physician as an employe or consultant.*

Earlier provisions have been enlarged by the addition of medical education and research organizations into its purview. The statute permits the contract to be either for employment or consultation. Before the 1973 amendment, the statute required only that a contracting staff consultant be a member of or acceptable to the medical staff. It did not require that the contracting physician be "subject to the approval of" the medical staff. As mentioned above, the emphasis has changed to give the physicians already involved in the institution decision-making authority.

The second requirement states a contract issue in a positive manner that subsection (d) states in a negative manner, that is, that no contract for medical services between a physician and a hospital or medical education and research organization may interfere with the physician's practice of medicine. This statutory requirement will be discussed in greater detail later.

The last provision requires that hospital contracts with an employed or consulting physician shall establish the physician's remuneration. An earlier statute used the same language but required that remuneration be on any basis other than a salary. The current law essentially authorizes the employment of physicians.

> (b) If agreeable to the contracting parties, the hospital or medical education and research organization may charge the patient for services rendered by the physician, but the statement to the patient shall indicate that the services of the physician, who shall be designated by name, are included in the departmental charges.

Under this provision, the contracting physician may elect whether to bill through or independently of the institution with which he or she contracts. An example of hospital billing is the "professional services" element seen on laboratory charges that indicates the fee for the services of the employed pathologist. If the physician bills separately, he or she may, but need not, use the institution as his or her collection agency. It probably is not practical for an *employed* physician to bill separately, but a *consulting* physician under contract with an institution clearly has an election in this respect.

> (c) No hospital or medical education and research organization may limit staff membership to physicians employed under this subsection.

The above provision forbids a hospital or medical education and research organization to close its staff membership to nonemployed physicians. This prohibition is important since it gives the individual physician the option whether to limit his or her relationship to the hospital to that of a private practitioner, whether to be a consultant to the staff under contract with the hospital, or whether to be employed by it.

This "closed staff" prohibition can be important in another respect. As the organizational nature of hospitals in particular undergoes changes in this state as seen by the movement toward proprietary and "MeSH" (joint venture between the hospital and medical staff) based hospitals, this prohibition will become more important. Under this provision, it would be illegal for a hospital, for example, which employs all physicians through a service corporation model, to close its medical staff membership to new applicants. This section does not, however, prohibit exclusive contracts such as a contract between a

hospital and an anesthesiology group, assuming that the hospital provides services beyond those offered by the department of anesthesiology.

(d) The responsibility of physician to patient, particularly with respect to professional liability, shall not be altered by any employment contract under this subsection.

As mentioned under (a) 1., the fee splitting statute is designed to authorize physician contracts with hospitals and certain institutions without allowing contracts to change the responsibilities of the physicians to their patients. The previous section assures that no contract may interfere with the physician's practice of medicine and this provision reinforces the concept by not allowing responsibilities and liabilities to be contracted away. This provision could be viewed as enabling a contracting institution to minimize its legal exposure and liability by keeping the contracting physician's liability as broad as possible. Unfortunately, the wording does not refer to or settle areas such as privilege or confidentiality, both of which are important to the patient and traditionally honored by physicians. It should be noted, however, that other provisions under state law regarding physician-patient privilege and records confidentiality are not affected by this section.

(6) **Definitions.** As used in this section:
(a) "Hospital" means an institution providing 24-hour continuous service to patients confined therein which is primarily engaged in providing facilities for diagnostic and therapeutic services for the surgical and medical diagnosis, treatment and care, of injured or sick persons, by or under the supervision of professional staff of physicians and surgeons, and which is not primarily a place of rest for the aged, drug addicts or alcoholics, or a nursing home. Such hospitals may charge patients directly for the services of their employe nurses, nonphysician anesthetist, physical therapists and medical assistants other than physicians or dentists, and may engage on a salary basis interns and residents who are participating in an accredited training program under the supervision of the medical staff, and persons with a temporary educational certificate issued under s. 448.04(1)(c).

This definition controls what is meant by the word "hospital" wherever it appears in the fee splitting statute. The last sentence of the subsection contains exceptions to the fee splitting law. The phrase "physicians or" just ahead of the word "dentists" can probably be considered impliedly repealed by the latter enacted provisions of the section. Otherwise, the services of a physician employed by a hospital could not be billed when he or she acted as a "medical assistant." It is believed that the Legislature intended that an institution that employs a physician should be able to bill for all of his or her professional services as a medical assistant.

(b) "Medical education and research organization" means a medical education and medical research organization operating on a nonprofit basis.

The above definition excludes a "hospital" as defined in (a) immediately preceding. The limits of the definition will depend upon the facts of a particular situation.

Medical staff responsibilities

This fee splitting statute analysis and comment addresses the rights of employed and consulting physicians and of the institutions that contract with either category. It is important for the interests of the patient, public, and good medical practice standards to also emphasize medical staffs' responsibilities under the fee splitting statute. Although it should not be assumed that cases of direct or indirect exploitation will arise, to minimize this chance and to correct any instance of exploitation, ***medical staffs must be aware of their responsibilities and that they share equal authority with hospital governing boards*** under contracting provisions of the fee splitting law, Section 448.08(5) of the Statutes. The authority of medical staffs is substantial under this statute. This authority includes and carries with it a corresponding responsibility on the part of medical staffs to satisfy themselves that:

(a) *Both* the governing board *and* the medical staff have independently determined *whether it is in the public interest* for the institution either to employ or to contract for the consulting services of a physician. If either body decides in the negative, no valid contract can be made with a particular physician as an employe or staff consultant.

(b) Any physician proposing to contract with an institution has the professional qualifications required for membership on the medical staff. This is the purpose of the statutory provision that a contracting physician is "subject to the approval of the medical staff." A contracting physician is not required to be a member of the institutional medical staff, but he or she must be "acceptable to" the staff. Although medical staff membership is not required by state statute, the hospital medical staff bylaws might provide that all physicians, including those contracting for consulting and other services, first be admitted to the medical staff.

(c) since the contract between an institution and the physician is predicated upon the public interest being served, and must meet certain statutory requirements, it follows that the contract itself is open to inspection by those having a legitimate interest in it.

For the same reason that the governing board of a contracting institution is entitled to review its agreement with a physician employe or consultant, the medical staff is similarly authorized to satisfy itself that the contract:

(1) Permits the contracting physician to exercise his or her professional judgment without supervision or interference by the institution;
(2) Establishes the remuneration of the physician;
(3) Makes billing arrangements for the contracting physician's services as permitted by the statute; and

(4) Does not alter the responsibility of physician to patient, particularly with respect to professional liability.

(d) Nothing in the contract supersedes the right of the medical staff to review and evaluate the professional qualifications of a contracting or consulting physician as often as a staff member is subject to this review and evaluation, including the right to determine whether it continues to be in the public interest that the contract remain in force. ■

Recently enacted communicable disease laws

MAJOR CHANGES in the Wisconsin communicable disease rule went into effect May 1, 1984. The new rule, referred to as Chapter HSS 145, Control of Communicable Diseases, represents the first significant revision of this rule in over 20 years. The rule (HSS 145) is particularly important to medical and public health professionals because it contains disease reporting responsibilities and a new list of reportable diseases, adopts standards for disease prevention and control, and updates other disease control activities.

HSS 145 replaces Chapters H 45 Communicable Diseases, H 46 Tuberculosis, H 47 Venereal Diseases, and H 49 General Regulations on Communicable Diseases. It is organized into three subchapters: Subchapter I, General Provisions; Subchapter II, Tuberculosis; and Subchapter III, Sexually Transmitted Diseases. HSS 145 requires specific disease prevention and control measures, as contained in *Control of Communicable Diseases in Man,* 13th edition (1981), published by the American Public Health Association. This manual is a familiar resource to most public health professionals and infectious disease specialists in the State and is updated every five years in light of new knowledge of disease mechanisms and the effectiveness of specific control measures. Physicians should use the control measures contained in this manual in the instruction of their patients. The State Epidemiologist may also specify other disease control recommendations necessary for the control of a specific disease or condition.

The reporting of communicable diseases is required of physicians, nurses, laboratories, health care facilities, teachers in schools and day care centers, and any other persons knowing of the presence of a communicable disease. The list of communicable diseases which are to be reported has been updated to reflect changing disease trends and the emergence of new diseases such as Acquired Immune Deficiency Syndrome, Legionnaires' disease, and toxic-shock syndrome (see complete list).

When a diagnosis of any of the diseases listed is suspected or confirmed, this fact must be reported (either verbally or by completing the Acute and Communicable Diseases Case Report form, DOH 4151) to the local health officer in the public health agency serving the patient's place of residence. The local health officer is required to forward all reports of communicable diseases to the State Epidemiologist at the Wisconsin Division of Health and is also responsible for coordinating the local epidemiologic followup of reported diseases.

(A *Directory of City and County Public Health Agencies in Wisconsin* for reporting communicable diseases is available from the Acute and Communicable Disease Epidemiology Section, Bureau of Community Health and Prevention, Division of Health, Department of Health and Social Services, PO Box 309, Madison, Wisconsin 53701; or phone: 608/267-9003.)

The tuberculosis control measures have been revised to reflect current knowledge about treatment and transmission of the disease. The list of sexually transmitted diseases covered by HSS 145 has been expanded to include genital herpes infection (first clinical episode only), nongonococcal urethritis, chlamydia trachomatis, nongonococcal cervicitis, and sexually transmitted pelvic inflammatory disease, in addition to syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum. Unnecessary restrictions of persons with sexually transmitted diseases have been removed. In addition, the "Sexually Transmitted Disease Treatment Guidelines 1982," published by the US Department of Health and Human Services, is adopted by reference in this rule.

Additionally, HSS 145 has eliminated previous archaic and unenforceable language, including: references to placarding, requirements for disinfection of library books by burning, restrictions on occupations of persons with venereal diseases, and regulations of dairies selling nonpasteurized milk (state statute now prohibits the sale of nonpasteurized milk).

Copies of Chapter HSS 145 are available from the Bureau of Community Health and Prevention, Wisconsin Division of Health, PO Box 309, Madison, Wisconsin 53701; or phone: 608/267-9003. Questions regarding specific provisions of this rule may also be addressed to the above agency. ■

This article was prepared by Susan J Stolz, MA and Jeffrey P Davis, MD of Madison and originally published in the June 1984 BLUE BOOK issue of the *Wisconsin Medical Journal.* It is being reprinted this year. Ms Stolz is from the Section of Acute and Communicable Disease Epidemiology (Communicable Disease Laws); and Doctor Davis is State Epidemiologist and Chief, Section of Acute and Communicable Disease Epidemiology.

Communicable diseases—Category I

The following diseases are of urgent public health importance and shall be reported by telephone to the local health officer immediately upon identification of a case or suspected case.

- Anthrax
- Botulism
- Botulism, infant
- Cholera
- Diphtheria
- Food- or water-borne outbreaks
- Hepatitis, viral Type A
- Measles
- Pertussis (whooping cough)
- Plague
- Poliomyelitis
- Rabies (human)
- Rubella
- Rubella (congenital syndrome)
- Tuberculosis
- Yellow fever

AIDS—Acquired Immune Deficiency Syndrome

The following is a list of AIDS educational and informational materials developed by the Wisconsin Division of Health (DOH). These materials are available from DOH in limited quantities upon request. All materials may be reproduced.

AIDS Update
- AIDS surveillance in Wisconsin.
- Centers for Disease Control National Statistics.

Prevention
- Infection precautions for people with AIDS and for persons providing direct care to persons with AIDS living in the community.
- AIDS inpatient infection recommendations and precautions.
- US Public Health Service. AIDS: precautions for clinical and laboratory staffs.
- Advice for AIDS patients.

Wisconsin Division of Health Advisories
- Emergency medical services guidelines for the prevention of Acquired Immune Deficiency Syndrome.
- Prison guidelines for the prevention of Acquired Immune Deficiency Syndrome.

Reference Materials
- Morbidity and Mortality Weekly Report and AIDS reference bibliography.

Social Services
- List of organizations providing services to persons at risk for AIDS.

Additional Materials
- Applying for Social Security benefits; the basic facts for people with AIDS.
- Questions and Answers on AIDS for healthcare providers.
- Order forms for "Living with AIDS: a Self-care Manual"—for persons with AIDS.
- AIDS: Do You Know the Facts?—Brochure on AIDS for college age population.

Requests for materials should be directed to:
Holly Dowling, Wisconsin Division of Health, 1 West Wilson St, PO Box 309, Madison, WI 53701-0309; telephone: 608/267-3583■

Communicable diseases—Category II

The following diseases are of less urgent public health importance and shall be reported to the local health officer by individual case report form or by telephone within 72 hours of the identification of a case or suspected case.

- Acquired Immune Deficiency Syndrome (AIDS)
- Amebiasis
- Blastomycosis
- Brucellosis
- Campylobacter enteritis
- Encephalitis, viral (specify etiology)
- Giardiasis
- Hepatitis, viral Types B, non-A non-B, or unspecified
- Histoplasmosis
- Kawasaki disease
- Legionnaires' disease
- Leprosy
- Leptospirosis
- Lyme disease
- Malaria
- Meningitis, aseptic (specify etiology)
- Meningitis, bacterial (specify etiology)
- Meningococcal disease
- Mumps
- Nontuberculous mycobacterial disease (specify etiology)
- Psittacosis
- Q fever
- Reye's syndrome
- Rheumatic fever (newly diagnosed)
- Rocky mountain spotted fever
- Salmonellosis
- Sexually transmitted diseases
- Chancroid
- Chlamydia trachomatis
- Genital herpes infection (first clinical episode only)
- Gonorrhea
- Granuloma inguinale
- Lymphogranuloma venereum
- Nongonococcal cervicitis
- Nongonococcal urethritis
- Sexually transmitted pelvic inflammatory disease
- Syphilis
- Shigellosis
- Tetanus
- Toxic-shock syndrome
- Toxic substance related disease
- Infant methemoglobinemia
- Lead intoxication (specify Pb levels)
- Other metal poisonings
- Other organic chemical poisonings
- Pesticide poisoning
- Toxoplasmosis
- Trichinosis
- Tularemia
- Typhoid fever
- Typhus fever
- Yersiniosis

Suspected outbreaks of other acute or occupationally-related diseases

Communicable diseases—Category III

The total number of cases or suspected cases of the following communicable disease shall be reported on a weekly basis to the local health officer.

Chickenpox

Unlike the previous rules which detailed control methods for each disease, the new rules adopt by reference the applicable methods of control contained in *Control of Communicable Diseases in Man*, 13th edition (1981), edited by Abram S Benenson, published by the American Public Health Association.

This rule became effective May 1, 1984.■

Legal responsibilities of the physician-patient-hospital relationship

SEVERAL QUESTIONS pertaining to the physician-patient-hospital relationship were addressed by the Society's legal counsel. The questions and excerpts from the opinion of legal counsel are presented below.

1. Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover or govern the question set out above. The basic statutes on hospitals relate to construction, safety, standards of maternity departments, and licensure.

In general terms, the courts have held that a physician has a legal responsibility to his patients, hospitalized or not, to furnish that degree of professional skill which meets the standard of professional care and to give such professional attention to the patient as the case requires. By statute the physician must inform patients of alternate viable modes of treatment. A physician is not legally excused for inattention to one patient on the grounds that he was occupied with the needs of others.

A physician has a continuing responsibility to his hospitalized patient at least to the point where the latter is well enough to be discharged, or sooner leaves without the physician's authorization. A physician may be charged with abandonment for neglecting a patient who needs his care, whether during or after hospitalization. Once a physician has agreed to care for a particular patient, he must continue to do so until the patient discharges him or no longer needs his professional services. He may be legally liable for neglect of the patient, or for ceasing to care for him until another physician has replaced him, unless he has been clearly discharged by the patient before the relieving physician actually takes over.

While a hospital nurse or technician may technically be in the employ of the hospital, a physician may incur legal liability for permitting a nurse or technician to carry out his treatment orders or assist him when he knows or has reasonable cause to know that such person is unsuitable for such duties by reason of inadequate training, experience, judgment or personality defect.

The essence of negligence is the absence of the degree of care owed by one person to another. Legal liability results when negligence causes physical injury or monetary damage to the object of such negligence. The principles of law involved are few, but their application depends upon the facts of the case, frequently as evaluated by expert testimony, and as found by a jury or court.

There also has been a recent trend toward the definition and codification of social or human rights of patients apart from their right to receive care meeting the appropriate standards of professional skill. A patients' bill of rights for nursing home and residential care facility residents has been enacted both by statute and administrative rule. Several hospitals have adopted or considered such a statement of rights. While not affecting the nature of care given, this expression of patients' rights does affect the environment within which this care is provided.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts in the past tended to distinguish the *administrative* negligence of a hospital from the *professional or medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital was liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

The distinction between the administrative and housekeeping functions for which hospitals were traditionally responsible and professional activities for which the physician was responsible has become blurred. Institutional liability for the negligence of its paraprofessional employees, frequently joint liability with independent physicians who are their immediate supervisors, is well settled. The 1965 *Darling* case in Illinois voiced a responsibility of the hospital to review and supervise the care given in a hospital. That case rested in part on the failure of hospital employees in observation and reporting but the principle established was broader. A leading Wisconsin case held a hospital liable for granting staff privileges to an incompetent practitioner. Other cases found liability for the failure of the medical staff to supervise physicians practicing in the institution and for the failure to establish quality review systems. While these all have administrative aspects, they also put the hospitals into potential jeopardy for the quality, or lack of quality, of care provided in the institution. Thus both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff and to some extent the care given in the institution. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to determine during the course of the trial that no liability exits against one or more of the parties sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility.* It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. So long as a contract between such a specialist and a hospital relating to his practice is in accordance with the fee splitting statute and other applicable laws, it is enforceable by him against the hospital and by the hospital against him.

The second area of legally enforceable rights enjoyed by staff physicians are those which relate to staff privileges as such. The documents which govern staff privileges are typically bylaws, rules and regulations, the application of an individual physician for staff privileges and the official action on such application, first, by the medical staff, and then by the governing body of the hospital. A physician whose staff appointment is regular in every respect acquires legally enforceable rights once he becomes a member of the medical staff. Those rights depend upon and are limited by the provisions of the hospital bylaws, rules and regulations, and by any particular conditions attached to his appointment, such as limitations on surgical privileges.

It is the proper business of the individual and collective membership of a medical staff to see that the granting of staff privileges, their limitation, suspension and termination are spelled out clearly, adequately and fairly. This is a matter of proper concern to patients whom the physician may hospitalize, and of enlightened self-interest to physician and hospital as well.

There appears to be a trend generally in the courts of this country to recognize something akin to a property right in hospital staff privileges *once they are granted,* so long as they remain in force, and assuming that the physician is not guilty of acts of professional negligence or misconduct. This means that the trend of the courts is away from permitting summary suspension or termination of staff privileges without a fair hearing, except for grave cause which might endanger patients or create liability on the part of the hospital.

Increasing importance should be attached to "negotiations" between the medical staff and the governing body or administrator of a hospital. These can be conducted by the Chief of Staff of a very small hospital, or by the Executive Committee of the medical staff of a larger hospital, in areas in which patient welfare and safety are involved, or in which tensions or conflict may arise between hospital policy and medical policy to the detriment of patient welfare. The latter are not matters of contract right as such, but are akin to "collective bargaining," and become a matter of understanding at the point the hospital and the medical staff are in agreement. They might include such areas as the unwillingness of the governing body of the hospital to follow medical staff recommendations for granting or limiting staff privileges; failure to purchase desirable or needed equipment or to replace equipment in the interests of patient safety or welfare; inadequate selection of the nursing, technical and other staffs of the hospital, or insufficient supervision and continued training during the course of employment. ■

Retention and inspection of patients' records

IT IS GENERALLY agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. Their beneficial ownership, that is the right to have them used for one's benefit, is in the patient although the right to possession remains in the physician or hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because of the long-standing uncertainty regarding the rights of physicians, hospital personnel, patients and others in regard to health care records, efforts both statutory and private have been made to clarify this situation. In 1959 the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* seeking to define what is a health record and restate the respective rights of various interested parties in them. This *Interpretation* was printed in the June 1975 Blue Book issue of the *Wisconsin Medical Journal.* (74 *WMJ* 30)

The law under which the *Interpretation* was prepared has been subsequently amended. To the extent of that amendment, the *Interpretation* is no longer valid. It does provide a framework from which to view the issues involved, this framework having been developed jointly by the health professionals most directly involved. The new statute, Sec. 804.10(4), Wis. Stats., is discussed in the box accompanying this article. It deals with authorization by a patient for the examination or inspection of that patient's health care records.

More recently, Secs. 146.81-.83, Wis. Stats., were enacted effective 1980. This new law deals with the release of health care records by consent and without consent. Health care records are defined as "all records related to the health of a patient prepared by or under the supervision of a health care provider." Consent may be given by the patient or one legally permitted to act on the patient's behalf. Consent must contain the name of the patient, the purpose of disclosure of the records, the type of information to be disclosed, the person to whom disclosure may be made, which providers are to make the disclosure, and the time period during which the consent is effective. Access without consent of the patient is permitted for staff, accreditation or review committee use, performance of health care services or consultation regarding them, billing, collecting and payment of claims, on court order, on written request from an appropriate government agency, and for research purposes subject to particular conditions. The new law also covers the subject of patient access to health care records.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

A. Retention of Records

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.
2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such

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unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.

3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.
   C. If the patient is a mentally normal minor at the time of treatment or hospitalization, suit for injuries resulting from alleged malpractice by a health care provider must be brought on behalf of the minor within the later of: (i) 3 years after the injury or (ii) one year from the date the injury was, or should have been, discovered within a maximum of five years after the alleged injury, or (iii) the time the minor reaches the age of 10.
   D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 20, or within three years from the date of the injury, whichever is later. If such patient remains insane after reaching age 18, his guardian must start suit within two years of his recovery, or before the patient is 20, whichever occurs later, all within a maximum of eight years after the alleged negligence.

4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

B. Inspection and Copying of Medical Records:

As a general rule, the right to inspect or copy medical records is based on the consent for such action by the patient or one legally authorized to act for the patient. The issue may arise in any of several situations and in the absence of a statutory exception covering the particular situation the physician should permit inspection and copying of a patient's medical records only by the patient or by one who has a written authorization from the patient (or one legally allowed to act on behalf of the patient) stating the extent of the authorization and describing the records covered by the authorization.

SECTION 804.10(4)

The general rule regarding inspection and copying of medical records is codified in Section 804. 10(4), Wisconsin Statutes. It is set out in the box below.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

STATUTE: 804.10(4)

"804.10(4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the physician (or his representative) or the hospital (or his representative), depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the authenticity of the signature or the mental capacity or age of the patient.

The statute authorizes the personal representative, or the beneficiary of a life insurance policy, to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Domiciliary Letters" or other documentary evidence of appointment or authorization which are issued by the Circuit Court branch handling probate matters.

In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) the person signing the authorization is the beneficiary under the policy.

The burden of proof is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized. On being satisfied that the authorization presented is properly signed, as previously outlined, that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the physician or hospital to permit such person to inspect and copy "any medical or hospital records or reports concerning" the care or treatment designated in the authorization. Exactly *what* records and reports may be inspected and copied is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be made available for inspection and/or copying.

It is believed that under a fair interpretation of subsection (4) the physician's records and reports (office or hospital), and the hospital clinical record or chart should be made available for inspection or copying.

In the case of x-rays there seems to be some disagreement among legal authorities as to whether they are part of the medical record as such, or are technically photographs. It is advised that x-rays be

inspected *only* under proper supervision, in the case of a physician's office by the physician in charge, an associate, or the designee of either, in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator.

X-rays must *not* be taken from the office of a physician or other custodian by a patient unless required by a court order or subpoena. When either of the latter is served on the custodian of medical records or reports, Section 804.10(4) *is no longer applicable,* and the authorization is no longer in force.

One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional responsibility of the attending physician and of those acting under him, and may be described as the "official records and reports." The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her/his acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care of treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. This statute does *not* require a physician or hospital to copy any records at the request of a patient or his representative. (See below, "Patient Access" under Section 146.83.) If a request is made by a patient or his representative, and the request is granted, the physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. (See below the elements of "informed consent.") The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

SECTIONS 146.81-.83

The most important exceptions to the general rule of confidentiality have been collected in Sections 146.81-.83, Wis. Stats. This law, adopted in 1979, defines the essential terms relating to "patient health care records," codifies the right of patients to have access to their records, recognizes the general rule of confidentiality of records, and enumerates the major exceptions to the general rule. A copy of Sections 146.81-.83 appears in boxes on following pages.

146.81 Definitions. In ss. 146.81 to 146.83:

(1) "Health care provider" means a nurse registered or licensed under ch. 441, a chiropractor licensed under ch. 446, a dentist licensed under ch. 447, a physician, podiatrist or physical therapist licensed under ch. 448, an optometrist licensed under ch. 449, a psychologist licensed under ch. 455, a partnership thereof, a corporation therof that provides health care services, an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 that directly provides services through salaried employes in its own facility, or an inpatient health care facility as defined in s. 140.85(1).

(2) "Informed consent" means written consent to the disclosure of information from patient health care records to an individual, agency or organization containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the types of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective.

(3) "Patient" means a person who receives health care services from a health care provider.

(4) "Patient health care records" means all records related to the health of a patient prepared by or under the supervision of a health care provider, but not those records subject to s. 51.30.

(5) "Person authorized by the patient" means the parent, guardian or legal custodian of a minor patient, as defined in s. 48.02(9) and (11), the guardian of a patient adjudged incompetent, as defined in s. 880.01(3) and (4), the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family, as defined in s. 632.78 (3) (d). A court may appoint a temporary guardian for a patient believed incompetent to consent to the release of records under this section as the person authorized by the patient to decide upon the release of records, if no guardian has been appointed for the patient.

146.815 Contents of certain patient health care records

(1) Patient health care records maintained for hospital inpatients shall include, if obtainable, the inpatient's occupation and the industry in which the inpatient is employed at the time of admission, plus the inpatient's usual occupation.

(2) (a) If a hospital inpatient's health problems may be related to the inpatient's occupation or past occupations, the inpatient's physician shall ensure that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(b) If a hospital inpatient's problems may be related to the occupation or past occupations of the inpatient's parents, the inpatient's physician shall ensure that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(3) The department shall provide forms that may be used to record information specified under sub. (2) and shall provide guidelines for determining whether to prepare the occupational history required under sub. (2). Nothing in this section shall be construed to require a hospital or physician to collect information required in this section from or about a patient who chooses not to divulge such information.

146.82 Confidentiality of patient health care records.

(1) CONFIDENTIALITY. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient.

(2) ACCESS WITHOUT INFORMED CONSENT. (a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

1. To health care facility staff committees, or accreditation or health care services review organizations for the purposes of conducting management audits, financial audits, program monitoring and evaluation, health care services reviews or accreditation.

2. To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to a person licensed under s. 146.35 or 146.50, including but not limited to medical staff members, employes or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if:

a. The person is rendering assistance to the patient;

b. The person is being consulted regarding the health of the patient; or

c. The life or health of the patient appears to be in danger and the information contained in the patient health care records may aid the person in rendering assistance.

3. To the extent that the records are needed for billing, collection or payment of claims.

4. Under a lawful order of a court of record.

5. In response to a written request by any federal or state governmental agency to perform a legally authorized function, including but not limited to management audits, financial audits,

continued on next page

1. Definitions

The statutory definitions of "health care provider," "Patient," and "patient health care records" are virtually all inclusive. Section 146.81, Wis. Stats. The law is intended to cover all health records of all patients of all providers.

In addition the law defines "informed consent." This is the statutory equivalent of the authorization referred to above. It means the *written* consent for disclosure of information from a patient's health care records and must include: the patient's name, the purpose for disclosure of the information, the type of information to be disclosed, to whom disclosure may be made, what providers must make the disclosure, the date of the consent, the period during which the disclosure consent is effective, and the signature of the patient or the "person authorized by the patient" (also a defined term).

As defined, "informed consent" is more specific and detailed than general authorization for inspection and copying records as discussed above. Because of the inclusive wording of the definitions it can be argued that all releases of information from health records are subject to this part of the law, notwithstanding the different phrasing of Section 804.10(4). For safety's sake it would be well to insist that any consent or authorization meet the standards of Section 146.81.

Other inconsistencies between the definitions in Sections 146.81 and 804.10(4) are relatively minor but may be significant in particular situations (e.g., disclosure of information from the records of a deceased patient).

2. Occupational Health

Physicians under Section 146.815 are to ensure that a hospitalized patient's records contain available information on the patient's occupation and health hazards related to it if the condition being treated may be occupation related. Information on the occupation of a patient's parents must also be included if relevant to the condition of the patient.

The responsibility under this section of the law is imposed on physicians but this information does not have to be obtained from any patient who refuses to disclose it.

3. Statutory Exceptions

The general rule of confidentiality of patient records is reiterated in Section 146.82. Following that statement the law lists six situations in which information from a patient's health care records may be released without informed consent. These include: management, financial, and service audits and accreditation; treatment or consultation regarding treatment of the patient; billing and collection of claims; under court order; government investigations; and research, where the product of this research will not identify individual patients. As to the last two (government investigation and research) private pay patients may deny access to their records by executing a form provided by the Depart-

continued from preceding page

program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department. The provider, if a hospital or nursing home, shall submit a copy of the signed form to the patient's physician.

6. For purposes of research if the researcher is affiliated with the health care provider and provides written assurances to the custodian of the patient health care records that the information will be used only for the purposes for which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final product of the research will not reveal information that may serve to identify the patient whose records are being released under this paragraph without the informed consent of the patient. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department.

(b) Unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.

146.83 Patient access to health care records.

(1) Except as provided in s. 51.30 or 146.82 (2), any patient or other person may, upon submitting a statement of informed consent:

(a) Inspect the health care records of a health care provider pertaining to that patient at any time during regular business hours, upon reasonable notice.

(b) Receive a copy of the patient's health care records upon payment of reasonable costs.

(c) Receive a copy of the health care provider's X-ray reports or have the X-rays referred to another health care provider of the patient's choice upon payment of reasonable costs.

(2) The health care provider shall provide each patient with a statement paraphrasing the provisions of this section either upon admission to an inpatient health care facility, as defined in s. 140.85 (1), or upon the first provision of services by the health care provider after April 30, 1980.

(3) The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

ment of Health and Human Services. (This form was not available for several months after the law became effective.) Anyone obtaining information under these exceptions may not, without court authority, disclose the information received.

Perhaps the most critical exception deals with governmental investigations. This includes the investigation of complaints by license law agencies. This exception exists if there is a written request by the agency and it is to assist it in performing a legally authorized function. The power to compel disclosure is conditioned upon the agency complying precisely with the law. If a physician receives such a request, care should be exercised to determine that it meets the requirements of the statute since this is an exception to the general rule of confidentiality.

Where the governmental investigation is being conducted to ascertain whether a physician has been guilty of unprofessional conduct, an administrative rule of the Medical Examining Board, Med 12.03(1), must be considered to determine whether the agency's powers are being lawfully exercised. This rule, which establishes the Examining Board's investigative procedures, permits such investigations to be conducted by an agent of the Examining Board acting under the supervision and direction of the secretary or another member of the Examining Board. There is some conflict in the law between the powers of the Examining Board and the Department of Regulation and Licensing in investigative matters but any investigation conducted under the authority of the Examining Board must meet its standards.

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ do hereby
(name of patient)

consent to and authorize _____,
(name of physician or health care institution)

to disclose to _____
(specific individual or organization)

information from my medical records relating to my identity, diagnosis, prognosis or treatment compiled during my medical treatment(s)/hospitalization from _____ (date) to _____ (date). I understand that the specific type of information to be disclosed includes: _____

_____

I understand that this consent may be revoked except to the extent that action has already been taken in reliance thereon, and that this authorization for disclosure will be effective until:

_____
(time or condition)

_____
Signature of Patient . . . . . OR

_____
Person Authorized by the Patient* and

_____
his/her relationship to patient

_____
Witness

Dated this _____ day of _____, 19____.

NOTE TO RECIPIENT OF INFORMATION. This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

*NOTE: Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent; the spouse or personal representative of a deceased patient; or any person authorized in writing by the patient which is witnessed and dated.

4. Patient Access

The law also addresses patient access to health records. Section 146.83, Wis. Stats. A patient or one with a patient's "informed consent" may inspect that patient's records at reasonable times, obtain copies of these records upon payment of reasonable costs, and receive copies of X-ray reports or have the X-rays referred, also upon payment of reasonable costs.

Physicians providing first services to a patient after April 30, 1980, are to provide a statement paraphrasing patient access rights to the patient. Physicians are to keep a log of patient access requests by time and date, person authorized to inspect the records, time and date of inspection, and identity of records inspected. ■

Patients' right of access to their medical records

A notice, which explains to patients the law requiring all physicians and hospitals to advise their patients of the patient's right of access to their medical record, is available to Society members for posting in their offices at a place easily seen by all patients. Patients may receive information from their record upon completion of an "informed consent" release form (see copy at left). Write: State Medical Society of Wisconsin, Attn: Communications Coordinator, PO Box 1109, Madison, Wisconsin 53701; or phone (608) 257-6781 Madison area or 1-800-362-9080 in Wisconsin. ■

"DENIAL OF ACCESS" FORMS. These forms can be purchased from either of the following printers: Wisconsin Printing and Bank Supply, PO Box 637, Menomonee Falls, WI 53051 (ph 1-800-325-8094), or HC Miller Co, 224-226 East Chicago St, Milwaukee, WI 53202 (ph 1-800-242-9971). They are *not* available from the State Dept of Health and Social Services or the State Medical Society.■

Denial of Researcher Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0003

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) In order to perform studies of health care, researchers affiliated with your health care provider may wish to review your health care records. These researchers have a legal duty to keep your identity confidential and to make sure that information from your health care records is not given to anyone who is not connected with the research.
2) State law says that a private pay patient may choose to keep researchers from reviewing his or her health care records; this may be done by signing the Denial of Researcher Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
3) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
4) If you sign this form and later change your mind and decide to let researchers review your health care records, you may cancel the Denial of Researcher Access statement below at any time by signing a written cancellation statement and giving it to your health care provider.

DENIAL OF RESEARCHER ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep researchers from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing a written cancellation statement. (S. 146.82 (2) (a) 6., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

Denial of Government Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0002

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) State and federal law directs government agencies to make sure that doctors, nurses, hospitals, nursing homes and other health care providers give health care of good quality in a safe setting and protect patient rights.
2) To make sure that health care services meet the basic legal requirements, state and federal agencies may need to review patient health care records. These records tell agencies how patients have been treated and can be very important during any investigation of alleged poor care, patient abuse, fraud, or patient rights violations. These agencies have a legal duty to keep the records they review confidential.
3) State law says that a private pay patient may choose to keep state and federal agencies from reviewing his or her health care records; this may be done by signing the Denial of Government Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
4) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
5) If you sign this form and later change your mind and decide to let state and federal agencies review your health care records, you may cancel the Denial of Government Access statement below at any time by signing the Cancellation Statement on the back of your copy of this form or your own cancellation statement and giving it to your health care provider.

DENIAL OF GOVERNMENT ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep state and federal agencies from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing the statement on the back of this copy or my own cancellation statement. (S.146.82(2)(a)5., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

(Note: If you are in a hospital or nursing home, a copy of this form will be sent to your private physician once it is signed.)

Questions about medical records laws

THE PRECEDING ANALYSIS of Wisconsin law regarding record retention and inspection provides a good starting point for understanding the law. However, in day-to-day applications of the records laws, situations arise where a basic understanding does not supply a ready answer. The following questions and answers are based in part on some of the inquiries forwarded to the State Medical Society's legal department.

Who else besides patients are authorized to inspect and obtain copies of medical records?

The law provides that all patient healthcare records are confidential and may be released only to persons designated in §146.82, persons with the patient's informed consent or others authorized by the patient. Parents of minors are generally authorized as the legal guardian to inspect and receive copies of their children's medical records with two exceptions: when the child received treatment for venereal disease or drug abuse. If the child's parents are divorced, either parent may have access to the medical records *unless the parent's rights have been terminated or limited by court order.* Other exceptions to records confidentiality and access are discussed below.

What happens when Worker's Compensation claims are involved or when insurance companies and attorneys not representing the patient ask for records?

The records release statute does not specify two other situations in which patient records may be released without the patient's authorization. Under Wisconsin Statute §102.13(2), a patient who reports an injury alleged to be work-related or files an application for a Worker's Compensation hearing waives any physician-patient confidentiality with respect to any condition or complaint reasonably related to the condition for which the patient claims compensation. In addition, §102.13(1)(c)3. states that any physician attending a Worker's Compensation claimant for any condition or complaint reasonably related to the condition for which the claimant claims compensation *may* furnish to the employe, employer, Worker's Compensation insurer, or the Department of Labor and Human Relations information and reports relative to a compensation claim. This section holds harmless any physician who reports on an injury or disability to a Worker's Compensation insurance carrier or employer without a release from the patient.

Another situation where the patient waives the physician-patient confidentiality usually protecting his or her medical records occurs when the patient files claim in a court of law where his or her medical condition is relevant to the claim or uses his or her medical condition as a defense in a civil or criminal case. In the same manner, medical information concerning facts or immediate circumstances surrounding a homicide at trial or a proceeding to determine a child's paternity, or test results for intoxication or blood alcohol concentrations are exempt under the patient record confidentiality protection otherwise afforded by law. In this instance and, in fact, in any situation where someone other than the patient is claiming access to medical records, the records custodian should require proof to the claim of legal authorization.

In addition, there are situations where state law *requires* physicians and other healthcare providers to disclose information without proper authorization otherwise needed. If after examining a child, a physician has reason to suspect child abuse or that the injury was not incurred by accident, the physician must breach the physician-patient confidentiality and report the incident to local authorities named in other statutory provisions.

Does a patient have a right to his or her medical records if the physician providing the medical services does so under contract with or at the direction of an insurance company, attorney, or court order because the patient's medical condition is at issue?

If a patient has been directed to submit to an examination by a court order or under the direction of an insurance company for the purposes of a Worker's Compensation claim or other injury claim, he or she does not have the right to control record disclosure (physician-patient confidentiality has been waived). This idea is discussed in the previous questions with regard to who has access to medical information. However, does the patient have a right to copies and access to this medical information about him or herself although he or she has not paid for the services? The most reasonable answer is that the patient should still have access to this information regardless of who paid for the services because of the records law policy that patients, with some exceptions, should be able to find out about their health and medical treatment.

What are some of the exceptions to the records inspection law with respect to access?

In a few instances, federal law preempts state law concerning access to medical records. One such federal exemption concerns The Privacy Act which limits access by federal agencies to certain information about individuals, including certain health information. Another exception to statutory access granted to individuals and agencies under Chapter 146 is found in Chapter 51, the Mental Health Act. This set of laws grants greater protection to records concerning treatment for mental illness, developmental disabilities, drug dependence and alcoholism than to general health records.

In addition to the limitations on access, there is a good argument that those not competent because of mental disease or defect are not entitled to the same right to inspect their health records generally granted under Chapter 146. In Chapter 51, several specific instances are stated where patients do have a right to their treatment records upon discharge from facilities where they underwent treatment for alcohol or drug addiction. However, no other guarantee to mental healthcare records is given by state law to those under the Mental Health Act's coverage—those receiving services for developmental disabilities or mental illness, and therefore, it is not clear whether those not legally competent because of their mental or emotional condition should or do have access.

Must I honor an insurance company's or attorney's request for copies of all the medical records regarding a patient?

All too often, a clinic or physician's office will receive a letter from an insurer or attorney accompanied by an authorization form signed by the patient requesting copies of all the medical records of the patient. For the most part, the patient is unaware that this request is made because they had previously signed a blank waiver form as a requirement for renewing or purchasing medical insurance. In many instances, the patient's records are voluminous and honoring this request would entail a substantial amount of staff time and office equipment use. If the authorization form does not state any limitation on records requested, the records custodian is required to supply all the information available, for a reasonable charge. However, after receiving this blanket request, the patient may revoke the authorization by signing another, more limited authorization for records release form. In this way, the records custodian can ask the patient, insurance company or attorney filing the waiver to restrict the request to those records relating to a specific medical condition or injury rather than the entire medical record.

Must I provide copies of a patient's records even if they have accounts in arrears?

There is no restriction to a patient's right to copy and inspect his or her records with regard to owing the physician or clinic money for the medical services provided. In other words, records cannot be held hostage for payment of outstanding bills. This prohibition appears in the AMA *Opinions of the Judicial Council of 1984* and can be interpreted from the absence of any condition of this sort at state law. A physician or clinic can attempt to withhold records for reason of nonpayment but will be exposed to the risk of paying court costs should the patient get a court order for the medical records under Wis. Stat. §804.10(4).

I understand that there is another statutory provision that limits copying charges to 10 cents a copy and $2 per x-ray—does this law apply to me?

In another section of the Wisconsin Statutes, there is a provision that limits the charge a hospital can make for reproducing records when involved in a suit as a party, under court order for cause shown, or upon a properly authorized request of an attorney. This provision, §908.03(6m)(b), therefore applies only to hospitals under the situation described and does not affect the copying charges permitted by law under Chapter 146. The only term used to describe what a healthcare provider may charge for copying records and x-rays is "reasonable." ■

NOTICE

Wisconsin hospital emergency rooms and outpatient facilities are aware of the following federal and state laws which prohibit . . .

I. Discrimination against patients

Alcohol abusers, alcoholics and drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse, alcoholism or drug abuse by any private or public general hospital or outpatient facility [as defined in section 1633 (6) of the Public Health Service Act] which receives support in whole or in part by funds appropriated to any federal department or agency. Such regulations shall include procedures for determining if a violation of subsection (a) has occurred, notification of failure to comply with such subsection, and opportunity for a violator to comply with such subsection.

U.S.P.L. 91-616, Part C, Section 321 A & B and subsequent amendments

U.S.P.L. 92-255, Section 407 A & B and subsequent amendments

II. Refusal of admission

"A private or public general hospital may not refuse admission or treatment to a person in need of medical services solely because that person is an 'alcoholic,' 'incapacitated by alcohol,' 'or is an intoxicated person' as defined in subsection (2). This paragraph does not require a hospital to admit or treat the person if the hospital does not ordinarily provide the services required by the person. A private or public general hospital which violates this paragraph shall forfeit no more than $500."

Wis. Stats. 51.45 (15) (c)

PLEASE NOTE: Hospitals not equipped to admit or provide treatment to the person must have a written plan and agreement with the nearest hospital that provides services required by the person.

Any violation should be reported to the Bureau of Alcohol and Other Drug Abuse, 1 West Wilson Street, Room 434, Madison, Wisconsin 53702. Phone 608/266-2717.

STATE MEDICAL EXAMINING BOARD

Hospitals required to report physician's loss of hospital staff privileges

A recently enacted state law requires hospitals to report to the Medical Examining Board peer investigation information which results in a physician's hospital staff privileges being lost or reduced for 30 days or more, or which results in a physician resigning from the hospital staff for 30 days or more.

Chapter 135, Laws of 1981, which became effective March 31, 1982, requires hospitals to notify the Medical Examining Board within 30 days after the loss, reduction, or resignation takes effect. Temporary suspensions due to incomplete records need not be reported.

Within 30 days after receiving a hospital report, the Medical Examining Board must notify the physician, in writing, of the substance of the report. The physician and the physician's authorized representative may examine the report and may place into the record a statement, of reasonable length, of the physician's view of the correctness or relevance of any information in the report. An action may be instituted in circuit court to amend or expunge any part of the hospital report.

If the Medical Examining Board determines a hospital report is without merit or that the physician has sufficiently improved his conduct or competence, the Board must remove the hospital report from the physician's record.

If no hospital reports are filed against a physician for two consecutive years, the physician may petition the Board to remove any prior reports, unless those reports are related to a finding of unprofessional conduct against the physician.

Hospitals may request information relating to a physician's loss, reduction, or resignation of staff privileges from other hospitals prior to admitting the physician to the medical staff.

Introduced at the request of the State Medical Examining Board as Senate Bill 68, the law is intended to prevent the migration of physicians who lose attending privileges at one hospital and to shortly thereafter receive approval for attending privileges at another, unsuspecting hospital.

The system requires the Medical Examining Board to act as a clearinghouse for the accumulation and dispersal of disciplinary actions taken by hospitals against physicians. ■

Watch your mail for the July issue containing the

1985 Membership Directory

including members' name, address, telephone number, practice specialties, and Board-certified specialties.

Members are encouraged to contact SMS headquarters for further information: Phone: 257-6781 in the Madison area or 1-800-362-9080 toll-free in Wisconsin; or write: State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701.

SMS members, you should know—

ABORTION. Wisconsin, like several other states, has a law denying subsidies from any public source for nontherapeutic abortions except in cases in which conception results from sexual assault or incest. Laws of this nature have been subject to challenge in the courts in other states. The validity of Wisconsin's law, if challenged, cannot be predicted. In Wisconsin spousal consent for abortion is not required by law. Physicians and hospitals are granted immunity from civil liability for refusal to perform abortions. In the case of the physician this immunity is conditioned on the refusal having been based on religious or moral precepts. No hospital, school, or employer may discriminate against a physician in regard to employment, tenure, or staff privileges or status for refusal to perform abortions if this is based on religious or moral precepts.

ABUSED CHILD LAW. *Wis. Stat. §48.981.* Child abuse by parents and others can be found at all economic, educational, and social levels. The Wisconsin Abused Child Law was enacted to prohibit child abuse in its many forms and prevent the cumulative effect of repeated beatings or other forms of severe abuse, including sexual exploitation, physical crippling, brain damage, or even death. Intentional infliction of emotional damage to a child is also considered child abuse under the law. The Abused Child Law makes it mandatory for physicians and others dealing with children to report suspected cases of child abuse and cases in which injury is threatened and abuse likely to occur. The law further provides that the reports be made to the city police departments, sheriffs, and county child welfare agencies. Civil as well as criminal immunity from suit is granted where a report is made in good faith. For further information, refer to the special report on child abuse in the January, February, and March 1985 editions of the *Wisconsin Medical Journal.*

ADOPTION PROCESS IN WISCONSIN. An *Information Memorandum,* published in the July 1982 BLUE BOOK issue of the *WMJ,* describes the process by which a potential adoptive parent adopts a child in Wisconsin. A child from Wisconsin or from another state or country may be adopted in this state with or without the services of an adoption agency. A list of adoption agencies appears elsewhere in this issue.

ADOPTION RECORDS LAW. Recent legislation in Wisconsin provides additional opportunities for adoptees and certain other persons seeking identifying information about their birth parents and information about medical and genetic history for themselves or certain other biological family. Chapter 359, Laws of Wisconsin, 1981, became effective May 7, 1982. Provisions of the new law are described in an *Information Memorandum 82-25* prepared by the Wisconsin Legislative Council staff. That memorandum was published in the July 1982 BLUE BOOK issue of *WMJ* and is available upon request to the *WMJ.* The law has been amended to provide for supplying nonidentifying social history of the child's birth parents. Chapter 471, Laws of Wisconsin, 1983.

AUTOPSY. Whose consent is required to permit a physician to conduct an autopsy? Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest permission for a physician to conduct a postmortem examination requires the consent of the person who assumes custody of the body for burial, providing that person is one of the following: father, mother, husband, wife, child, guardian, or next of kin. If none of these persons is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient. Section 979.03, Wis. Stats., requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

Sudden infant death (SID) syndrome. Section 979.03, Wis. Stats., requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

CERTIFICATION. Wisconsin physicians are reminded that it is their responsibility, as well as to their advantage, to keep WPS-Medicare informed of any change in their specialty or certification status. To alleviate any confusion, each physician should be sure that the same specialty is shown with the various societies; *eg,* AMA, State Medical Examining Board, and the State Medical Society. There have been some instances where a different specialty was shown with each organization. Written documentation of such changes should be directed to the WPS-Medicare, PO Box 1787, Madison, WI 53701, ATTENTION-CPCU

continued next page

(Central Provider Control Unit). If you have any questions concerning the specialty WPS-Medicare currently has on file for you, contact Mrs Johnson, CPCU, (608) 221–4711, ext 420. Physicians also are urged to provide the same information to the Medicaid administrator: EDS-Federal, Attention Provider Maintenance. The contact person is Gary Holtzman (phone: 608/221–4746).

CHILD SAFETY RESTRAINT SYSTEMS. ***347.48(4)(a) Wis. Stats.*** No resident may transport a child under the age of 2 in a motor vehicle unless the child is properly restrained in a child safety restraint system approved by the department. "Properly restrained" means fastened in a manner prescribed by the manufacturer of the system which permits the system to act as a body restraint but does not include a system in which the only body restraint is a safety belt of the type required under sub. (1). The department shall, by rule, establish standards in compliance with applicable federal standards for approved types of child safety restraint systems for those child restraint systems purchased after November 1, 1982. No resident is required to have more than 3 child safety restraint systems in a vehicle.

No resident may transport a child who is at least 2 years old but less than 4 years old in a motor vehicle unless the child is properly restrained in a child safety restraint system approved by the department under subd. 1. or in a safety belt approved by the department under sub. (2). "Properly restrained" means fastened in a manner prescribed by the manufacturer of the system which permits the system to act as a body restraint.

When a parent is present in a vehicle operated by a resident other than the parent, the parent is responsible for complying with the law.

CLOSING A PHYSICIAN'S OFFICE. Several articles in this issue contain information that may be helpful to physicians or their spouses when closing an office: 1) "Some considerations before opening a physician's office," 2) "Problems of a physician's widow/er," 3) "Retention and inspection of patients' records," 4) "The use of consent and related forms for physicians," and 5) "Narcotics" (what to do in case of a physician's death).

COMMUNICABLE DISEASES. The State Department of Health and Social Services recently implemented new administrative rules regarding communicable diseases. The rules merge all communicable disease regulations into a new chapter, HSS 145, of the Wisconsin Administrative Code. Physicians, nurses, laboratores, healthcare facilities, or any other person identifying a case or a suspected case of communicable disease must report its existence to the local health officer. Further details, including a listing of communicable diseases, appear elsewhere in this issue.

CONSENT AND RELATED FORMS FOR PHYSICIANS. A number of these forms which a physician may have occasion to use in his regular everyday practice appear in an article, "The use of consent and related forms for physicians," elsewhere in this issue. Related information also is included, particularly reference to Chapter 375, sec. 448.30 Wis. Stats., relating to requiring physicians to inform their patients of alternate modes of treatment, granting rule-making authority, and creating a penalty.

"DENIAL OF ACCESS" TO HEALTHCARE RECORDS. These forms can be purchased from either of the following printers: Wisconsin Printing and Bank Supply, PO Box 637, Menomonee Falls, WI 53051 (ph 1-800-325-8094), or HC Miller Co, 224-226 East Chicago St, Milwaukee, WI 53202 (ph 1-800-242-9971). They are NOT available from the State Dept of Health and Social Services or the State Medical Society. Sample copies of the forms appear elsewhere in this issue.

DETERMINATION OF DEATH. Wisconsin law (Chapter 134, Laws of 1981) provides that 146.71 of the statutes is created to read: ***Determination of death.*** An individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death shall be made in accordance with accepted medical standards.

DISABILITY CLAIMS. Under a recent court order the Social Security Administration will review certain disability claims in Illinois, Indiana, Ohio, Michigan, Minnesota, and Wisconsin, where individuals with mental impairments were either denied disability benefits or terminated from the disability rolls. Certain individuals who were either denied social security disability benefits were terminated on or after March 1, 1981, and before January 4, 1983, who alleged a mental impairment (other than mental retardation) and who were be-

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tween the ages of 18 and 49 may have their eligibility reviewed. If because of your special concerns for the mentally impaired you know of anyone who meets these requirements, the SSA of the US Department of Health and Human Services asks that you advise that person to either visit or telephone the local social security office to obtain further information. If you are representing such a person, you may contact a social security office on behalf of that person.

DONATIONS OF ORGANS, BODY. Wisconsin, along with some 40 other states, has adopted the Uniform Anatomical Gift Act, a law under which a donor may leave all or any part of his/her body for research or transplantation. With the continuing publicity given to transplant technology, physicians are being queried about the law and how their patients may make anatomical gifts. To assist physicians in providing the necessary information to patients, the University of Wisconsin-Madison Anatomy Department and the Medical College of Wisconsin Department of Anatomy have provided the State Medical Society with policy statements in the acceptance of bodies. These statements appeared in the June 1981 BLUE BOOK, on pages 46–47. Further information may be obtained by contacting the Medical College of Wisconsin, Department of Anatomy, 8701 Watertown Plank Road, Wauwatosa, Wis 53226 (mailing address: PO Box 26509, Milwaukee, Wis 53226; or phone 414/257–8261); or University of Wisconsin-Madison, Anatomy Department, Bardeen Medical Laboratories, 1300 University Ave, Rm 325 SMI, Madison, Wis 53706 (phone: 608/262–2888).

Uniform Organ Donor Cards and Decals. These are available from the National Kidney Foundation of Wisconsin, Inc, 6701 Seybold Rd, Madison, Wis 53719 (phone 608/274–0441), or 7332 West State St, Wauwatosa, Wis 53213 (phone 414/453–2830).

Donation of eyes. Inquiries may be directed to the Milwaukee Eye Bank, 8700 West Wisconsin Ave, Milwaukee, Wis 53226 (phone 414/257–5543), or to The Eye Bank, E5/410 Clinical Science Center, University of Wisconsin-Madison, Center for Health Sciences, 600 Highland Ave, Madison, Wis 53792 (phone 608/263–6223).

"Living will" on use of measures to sustain life. Many people express their desire that no "heroic" measures be used to sustain their physical functions if this would result in their being totally incapacitated, comatose, or otherwise severely impaired. Various forms of a "living will," purporting to direct the scope of care to be given or withheld in such situations have been prepared and are in circulation. The 1983-84 Legislature addressed itself to this issue and enacted Assembly Bill 513 which created Chapter 154 of the statutes relating to authorizing adult patients to direct the withholding or withdrawal of life-sustaining procedures if the patient becomes terminally ill and providing a penalty. The new law, 1983 Wisconsin Act 202, which appeared in its entirety in the June 1984 BLUE BOOK edition of the *Wisconsin Medical Journal,* provides the basis for physicians in drawing up a "living will" document.

DRIVERS' LICENSES FOR EPILEPTICS. A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if: (1) He or she submits with his/her application a certificate from a licensed physician recommending that a temporary driver's license be issued, and (2) He or she is otherwise qualified to obtain a license. The certificate is a form prepared by the Department of Transportation and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety. For two years following the issuance of the license the epileptic is required to present medical certificates to the Department of Transportation at six-month intervals and yearly thereafter on the licensee's birth date until the licensee has been free of seizures for a period of 10 years from the date of issuance of the license, except that in no event is such license valid beyond the date of expiration shown on the license. On such date, the license is subject to renewal. The issuance of a temporary license is discretionary with the Department of Transportation. A denial may be reviewed, however, by a special board. Prior law had required the epileptic to file yearly medical certificates following the two-year initial period in which the epileptic was required to submit certificates at six-month intervals.

DRUG SUBSTITUTION LAW—In April 1984, Senate Bill 365 became effective. This bill eliminated the Wisconsin Drug Quality Council and Drug Formulary, adopted the Food and Drug Administration's "Approved Prescription Drug Products with Therapeutic Equivalent Evaluations," prohibits preprinted state-

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ments on prescription order blanks regarding drug substitution, and set up other measures to assure consumer choice of less expensive drug equivalents. Under the law, physicians continue to have the authority to prohibit substitutions by noting on the prescription order so long as this prohibition is not a preprinted statement. Since the State Department of Health and Social Services will no longer publish the Wisconsin Drug Formulary and Wisconsin Administrative Code section HSS 127 is repealed, pharmacists and others interested can obtain the FDA list by contacting: Superintendent of Documents, Government Printing Office, Washington, DC 20402; (202) 783-3238. A more comprehensive explanation of SB 365 appeared in the June 1984 edition of the *Wisconsin Medical Journal.*

ELDERLY ABUSE. Each county is now required to designate a county agency to receive reports of abuse or neglect of elder persons. Anyone may report situations in which facts or circumstances leading to a reasonable belief that an elder person (60 years or older or subject to the infirmities of aging) has been the victim of physical or financial abuse, neglect or self-neglect. Reports made in good faith are immune from civil liability. Physicians may be expected to have more opportunities than others to observe reportable facts and circumstances. Chapter 398, Laws of Wisconsin, 1983.

EMPLOYEES ALLOWED TO INSPECT RECORDS UNDER LAW. Physicians as well as other employers in the state should note the personnel records inspection law which became effective May 21, 1980. The law gives the employee the right to inspect any employer-maintained personnel records used in hiring, promoting, transfering, giving raises, or terminating that employee as well as certain medical records. The employer is required to grant the employee at least two requests to view records per calendar year, each within seven days of the request, and at a location convenient to the employee during working hours, or other agreeable arrangement. Employers may require that request in writing. An employee involved in a current grievance against the employer may designate in writing a representative, such as a union agent, to inspect the personnel records. Upon agreement of the employer and employee, any errors or differences of opinion may be noted in the record. If an agreement cannot be reached, the employee may add a written statement, to become part of the permanent file, expressing his/her opinion. The employee may also inspect any of his/her medical records that are in the employer's file. If the employer feels these medical records would be detrimental to the employee, the employer may release them to the employee's physician or the employee's immediate family. The employer may withhold some information under the law. Among the exceptions are: any records relating to possible criminal offenses, letters of reference, test documents (the employee may see the test scores), information about a third person, records relating to a pending legal claim between employer and employee, or material used by the employer for staff management planning. For complete details refer to Section 103.13, Wisconsin Statutes.

GOOD SAMARITAN LAW. The Legislature has broadened the immunity provided by the Wisconsin Good Samaritan Law to cover any person rendering aid at the scene of an emergency. First enacted to protect physicians, these laws are common throughout the United States. They are designed to encourage prompt care for persons who are injured or become ill away from normal locations where treatment is given. The scene of an emergency does not include a hospital or physician's office. Persons employed and trained to render emergency care, acting for compensation and within the scope of their employment are not protected under the law.

IMPLIED CONSENT LAW. The theory of Wisconsin's implied consent law is that every person (including minors) using the state's roads is presumed to have consented to testing for alcohol and controlled substances if he or she is arrested for a violation involving driving under the influence of an intoxicant. (A preliminary breath test may be given before arrest, but this will not involve physician participation.) This presumption is overcome if the individual refuses to submit to the test, but refusal may result in suspension of his driving privileges and a severe sentence if he is convicted of driving under the influence of an intoxicant. A person who is unconscious is presumed not to have withdrawn his consent to such chemical testing. If the driver does not refuse to take a test, one may be given upon request of a traffic officer. The test may be blood, breath or urine, and the law enforcement agency administering the test is to designate which one shall be used. The law says who may draw blood for testing purposes. This is a procedure which should be done only by or at the direction of a physician. When acting upon the request of a traffic officer to draw blood, the one drawing blood is immune from civil or criminal liability except for civil liability for negligence (malpractice) in doing so, providing the person has been arrested under certain specified statutes. Records of

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blood-alcohol tests conducted under the implied consent law are not "health care records" for purposes of statutes related to the confidentiality of records and the physician-patient privilege does not apply to the results of or circumstances surrounding such tests. Recommended physician guidelines and a sample form for request/consent for drawing blood were published in the July 1982 BLUE BOOK issue of *WMJ*. A reprint of the article and reproducible form is available to SMS members at no charge under auspices of the CES Foundation; available to others at a cost of $3.00 plus 5% state sales tax to: CES Foundation, Attn: Drawing Blood Consent Form, PO Box 1109, Madison, WI 53701; phone 257-6781 in Madison area or 1-800-362-9080 in Wisconsin.

JAIL HEALTH CARE IN WISCONSIN. Since 1976 the State Medical Society of Wisconsin has been working with interested sheriff's departments on a *voluntary* basis to develop health care systems using the AMA's Standards for Health Services in Jails, in Juvenile Correctional Facilities, and in Prisons. Although the AMA does the accrediting of jails, the State Medical Society provides ongoing consultation which includes technical assistance emphasizing the use of existing community resources such as the county nursing service and mental health and alcoholism counselors from the Unified Services Board. Interested physicians or institutions desiring more information on what constitutes adequate care for incarcerated persons may contact the State Medical Society of Wisconsin, Attn: Jail Health Care Technical Assistance Committee, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin.

JOINT PRACTICE: PHYSICIANS AND NURSES. Reprints of the following items, which were published in the June 1981 BLUE BOOK issue of the *WMJ*, are available upon request to: State Medical Society of Wisconsin, Attn: Joint Practice Committee, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin: (1) ***Guidelines for Implementation of Joint Practice of Physicians and Nurses***, (2) ***Statement on Joint Practice***, and (3) ***Guidelines for Institutional Joint Practice Privileges.***

JURY DUTY. Physicians are no longer automatically exempt from serving as a juror. However, there are some qualifying circumstances under which a physician might be excused in the discretion of a judge for hardship or extreme inconvenience. Physicians interested in further details may contact the State Medical Society of Wisconsin, Attn: Physicians Alliance Division, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin.

LICENSURE IN WISCONSIN. The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties. Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

LIVING WILLS—THE NATURAL DEATH ACT, Chapter 154. On October 1, 1984, Wisconsin's Natural Death Act became effective. This legislation authorizes physicians and healthcare institutions to honor patients' prospective requests regarding their treatment as evidenced by documents called "living wills" when afflicted with a terminal condition. The law sets up specific circumstances under which living wills become effective and where the documents must appear in the patient's medical records. The full text of the law appeared in the June 1984 edition of the *Wisconsin Medical Journal.*

MEDIC ALERT FOUNDATION INTERNATIONAL, a nonprofit, tax-exempt organization, provides life-protecting services such as bracelets designed to alert emergency personnel to hidden medical conditions. The Medic Alert emblem is imprinted on the front side and on the back is the member's hidden medical condition along with an ID number and 24-hour emergency telephone number which can be utilized to retrieve the computerized emergency medical data within seconds. Information that is stored can include physician's telephone number, type of insurance policy, next-of-kin, blood type, medication name and dosage. Free information is available from *Medic Alert*, Turlock, California 95380.

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MINOR'S CONSENT. A common question from physicians throughout the state is under what circumstances may a physician provide medical services to a minor without parental consent. As a general rule, consent for medical services to be provided to an unemancipated minor must be given by the minor's parent, guardian, or court-appointed sustaining parent. Under appropriate circumstances a court may give consent in lieu of a parent. Emancipation occurs when a minor is no longer under parental care and custody. A common example of emancipation is marriage by a minor. Wisconsin law also provides that a minor may receive diagnosis of and treatment for venereal disease, Wis. Stats. §143.07, and drug abuse, Wis. Stats. §51.47, without parental consent. Attempts to expand this law to include all medical care have failed. This area of the law, parental rights versus minors' right of privacy, is now quite active and physicians should be alert to rulings which bear on this conflict.

NEWBORN INFANT EYE DROPS. The permanent administrative rule allowing the use of either silver nitrate, tetracycline, or erythromycin for the prevention of gonococcal ophthalmia in newborn infants became effective October 1, 1980. The rule also changes the time frame in which the preventive agent must be administered after birth from "immediately" to "as soon as possible, but not later than one hour after birth." Under the rule only one child shall be treated per container.

OPENING A PHYSICIAN'S PRACTICE. Some considerations for physicians to note when opening a medical practice are outlined in an article "Some considerations before opening a physician's office" elsewhere in this issue. Physicians also are reminded that the annual BLUE BOOK issues of *WMJ* are excellent sources of information whether opening a practice for the first time or moving a practice to Wisconsin. Reprints of this year's issue, as well as previous issues, are available upon request to the *Wisconsin Medical Journal*, PO Box 1109, Madison, Wis 53701, or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin. Cost: $15.00 plus 5% sales tax in Wisconsin, unless tax-exempt status declared.

OPTOMETRIST REFERRAL LAW. Several publicly and privately sponsored glaucoma screening programs have inquired of the State Medical Society as to whether it is appropriate to refer persons suspected of elevated intra-ocular pressure directly to an appropriate medical specialist for further evaluation. The question arises because one section of the Wisconsin Statutes, 449.01 (3), requires any agency of the state, county, municipality, or school district to give the recipient of a vision screening program equal opportunity to choose between optometric or physician services for follow-up as a consequence of vision screening activities. At the same time, another section of the statutes, 449.19, which was passed at a later date by the Legislature, requires that an optometrist who determines the possibility of the existence of a pathologic condition to refer the person examined to an "appropriate medical specialist" for further evaluation. The State Medical Society believes that the implication of these statutes, when taken in combination, is clearly a legislative intent that whenever there is the possibility of the existence of a pathologic condition, the patient should be referred to an appropriate medical specialist for further evaluation. The Legislature's action was a recognition of the seriousness of possible pathology in the eye and the urgency and importance of referral to medical care. The Medical Society therefore feels it appropriate that a public health nurse or other person who as a result of screening tests believes there is reason to suspect glaucoma should immediately refer directly to an ophthalmologist or other appropriate medical specialist. At the same time, the Medical Society wishes to emphasize that the policy of nondiscrimination for referral to optometrists or physicians following tests for visual acuity must be respected and is encouraged.

PATIENTS' RECORDS/RETENTION AND INSPECTION. Information on this subject appears in an article entitled, "Retention and inspection of patients' records," elsewhere in this issue and will not be repeated here. However, briefly stated the statute 804.10(4) reads: "Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

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PATIENTS' RIGHT OF ACCESS TO THEIR MEDICAL RECORDS. A notice, which explains to patients the law requiring all physicians and hospitals to advise their patients of the patient's right of access to their medical record is available to Society members for posting in their offices at a place easily seen by all patients. Patients may receive information from their record upon completion of an "informed consent" release form (see copy of form in article "Retention and inspection of patients' records" elsewhere in this issue). Write: State Medical Society of Wisconsin, Attn: Communications Coordinator, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin.

PHYSICAL THERAPY RELATING TO PRACTICE. An Attorney General's opinion, issued in April 1982 regarding two issues relating to the practice of physical therapy, fee splitting, and professional service corporation, appeared in the July 1982 BLUE BOOK issue of *WMJ* and will not be repeated here. The following is a capsule opinion: There is no violation of the "fee splitting" statute, sec. 448.08(1), Wis. Stats., where a physician, through a service corporation owned by the physician, bills the patient for his own services, and that of physical therapist employed by the corporation, provided the billing states an accurate dollar figure for the respective services. A medical professional service corporation is not in violation of sec. 180.99(2) Wis. Stats., when physical therapists are on the staff of the corporation.

PHYSICIAN-PATIENT-HOSPITAL RELATIONSHIP. Questions pertaining to this issue are addressed in an article entitled, "Legal responsibilities of the physician-patient-hospital relationship," which appears elsewhere in this issue.

PHYSICIAN'S ASSISTANTS (PA). Under Wis. Stat. §§15.08(5), 227.04, 448.40, the State Medical Examining Board governs the certification and regulation of physician's assistants. The Wisconsin Administrative Code contains specific regulatory codes regarding the physician's assistant's scope of practice, supervision by physicians, and the new prescribing rules found in Med 8.08. Under the new prescribing rules, the supervising physician may direct a PA to prepare a prescription order only if:

—a written protocol is used and reviewed annually;
—it is mutually determined that a PA is qualified through training and experience to prepare prescription orders as specified in the protocol;
—when practicable, the PA consults directly with the supervising physician prior to preparing an order;
—the order includes the supervising physician's telephone number, the PA's address; and
—the physician either reviews and countersigns before, within one day of preparation, or reviews within 48 hours and countersigns within one week.

PAs may not prepare a prescription order for a controlled substance, as defined in §161.01(4).

Chapter Med 8 of the Wisconsin Administrative Code, stating the rules under which the Medical Examining Board must govern physician's assistants, was published in toto in the July 1982 BLUE BOOK issue of the *WMJ*. Copies are available upon request to *WMJ*.

PREMARITAL EXAMINATIONS. Previous statutes requiring couples to have premarital (VD screening) examinations have been repealed. The physician's practice of giving complete physical examinations or representing complete physical examinations is no longer a mandatory requirement of the statutes.

STANDARD CASUALTY MEDICAL REPORT FORM. In 1963 the State Medical Society of Wisconsin and the Wisconsin Claims Council developed an agreement whereby a doctor who files a standard short report form without charge receives insurance company support of his or her financial interest at the time of payment. The casualty companies and the State Medical Society devised the form to protect the interests of doctors, companies, and insureds. Because it is the standard report form recognized by the Society, it cannot be changed by any insuror other than to add the logo of the insurance company requesting the information. Physicians are cautioned that this agreement only applies to the short form. If a physician is asked to file a lengthy narrative report by the insurance company, he or she should expect payment for this additional service. Physicians usually get these forms from the insurance company involved. ■

LET THESE GUIDES HELP YOU

THE FOLLOWING GUIDES and manuals have been prepared or obtained at the direction of the Board of Directors and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept., State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.

- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.

- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.

- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Revised 1978—Single copy 25¢ with order.)

- **If You Have a Complaint About Medical Care**—Medical care is a personal matter between patient and physician. Yet, sometimes misunderstandings arise about what the physician hopes to accomplish and what the patient expects. This brochure, aimed at patients, explains the State Medical Society's grievance and peer review system.

- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $2.00 plus 5% sales tax with order.)

- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10″x11½″. For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $11.00; complete guide without binder: $10.00—to accompany order.)

- **Make Yours a Smokeless Pregnancy**—Points out the dangers of smoking during pregnancy and its effects on the fetus.

- **Retention and inspection of patients' records**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.

- **Legal Responsibilities of the Physician-Patient Relationship**

- **Putting the UCR Fee Puzzle Together**—Explains what "usual, customary and reasonable" means, how misunderstandings concerning it can be avoided and how problems can be resolved when they occur. The small size of the brochure makes it suitable for enclosure in office statements or for placement in patient reception areas.

- **Guide to the Service Corporation Law**

- **Some Straight 'Dope' on Marijuana**—Increasing evidence appearing regularly that marijuana is hazardous to health has led the State Medical Society of Wisconsin to declare it to be a dangerous drug. This brochure explains what marijuana is, who uses it, and points out some of the psychological and physiological hazards associated with its use.

- **Rubella—Red Measles Brochure**—This conveniently sized 2½″x4″ sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.

- **Getting the Most Out of Your Health Care Dollar**—Explains the reasons for rising health care costs and offers advice on what the patient can do to control them.

- **Alcohol and Your Unborn Baby . . .**—Warns women of the harmful effects alcohol can have on an unborn child. Available in both English and Spanish versions.

- **To All My Patients, Partners in Good Health**—Explains the rights and responsibilities physicians and patients have in medical care. Available in standard brochure or smaller "statement stuffer" form.

- **I Want To Know What You Think**—a questionnaire physicians can use with patients to elicit their attitudes and opinions regarding his/her medical practice.

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STATE DEPARTMENT OF REGULATION & LICENSING

Physician licensure verification procedure

The Department of Regulation & Licensing offers several avenues available to verify the licensure of medical professionals.

A. Purchase of the Department's current master printout of licensees (name, address, and license number) at a cost of about $60 for all licensees of the Medical Examining Board. Contact the Department's Renewal Section at (608) 266-0627 for further information and ordering.

B. Purchase of the Department's directory of Medical Board licensees which is current up to December 1984, contains no license numbers, and costs $6.30.

C. Checking, at the physician's facility, the current registration card of all Medical Board licensees. That certificate, stamped "valid to December 1985" is the physician's proof of being currently registered with the Medical Examining Board.

D. Writing or calling the Medical Board office when the following is true:

1. Applicant for staff privileges is not listed in the printout or directory.
2. Applicant for staff privileges cannot produce a current registration card.
3. Applicant is a new licensee in Wisconsin.
4. A person has good reason to believe the Medical Examining Board has disciplined the licensee and vertification of that fact is desired.

Physicians who have been members of a hospital or clinic medical staff for a number of years will be expected to show their license "renewal card" every two years to the staff.

A physician experiencing no problems on a medical staff, having a current renewal card, and not listed in the *Digest of Rules and Discipline* will not show up as a problem on the Department's records.

The Department of Regulation & Licensing and the Medical Examining Board have told the State Medical Society that they wish to assure effective regulation of the profession to the citizens of Wisconsin and, therefore, are most anxious to assist physicians in the verification process. ■

Physician re-registration

EVERY TWO YEARS physicians are required to re-register their license. As a part of this process physicians are required to attest to their having attained 30 hours of AMA Category 1 Continuing Medical Education Credits.

This requirement is subject to audit by the State Medical Examining Board. In this case physicians would be required to prove their attendance at continuing medical education programs that would grant them at least 30 hours of Category I Credit Hours in the previous two-year period.

Currently physicians are licensed for 1984 and 1985 and will be next required to attest to CME with re-registration forms mailed late in 1985 for their 1986-87 license. Physicians are reminded to let the Medical Examining Board know of any address change (the post office only forwards for a six-month period). All fees associated with re-registration must be received by the Medical Examining Board by December 31 of the year re-registration occurs. ■

LET THESE GUIDES HELP YOU continued

- **Getting the Most Out of Your Health Care Dollar**—Offers tips on how patients can spend their health care dollar wisely and be a cost conscious patient. The brochure also shows where the Nation's Health Care Dollar is spent and explains what doctors are doing to control costs.

- **UPDATE—Health Maintenance Organizations: The Wisconsin Law**—Explains health maintenance organizations (HMOs) and how they are organized under Wisconsin law. A summary of SMS concerns with the law is included as well as the Society's proposed alternative legislation.

- **UPDATE—Medical Liability in Wisconsin: Problems and Recommendations for Change**—Provides an overview of the problem of medical liability in Wisconsin and offers State Medical Society recommendations for resolving it.

- **Medical Liability—A Physician's Rights and Responsibilities**—Provides information about medical liability insurance and outlines the rights and responsibilities of physicians and medical liability insurance carriers in the resolution of medical liability disputes.

- **UPDATE—Prospective Hospital Reimbursement: DRGs**—Looks at the new prospective payment system utilizing Diagnosis Related Groups (DRGs) and examines how it will affect physicians, patients, and hospitals. ■

Wisconsin Administrative Code

MEDICAL EXAMINING BOARD

Chapter Med 18

ALTERNATE MODES OF TREATMENT

Med 18.01 Authority, purpose and scope
Med 18.02 Definitions
Med 18.03 Communication of alternate modes of treatment
Med 18.04 Exceptions to communication of alternate modes of treatment
Med 18.05 Recordkeeping

Med 18.01 Authority, purpose and scope. (1) AUTHORITY. The rules in this chapter are adopted pursuant to authority in ss. 15.08 (5)(b), 227.014, and 448.40, Stats.

(2) PURPOSE. The purpose of the rules is to define the obligation of a physician to communicate alternate modes of treatment to a patient.

(3) SCOPE. The scope of the rules pertain to medical and surgical procedures which may be prescribed and performed only by a physician, as defined in s. 448.01 (5), Stats.

Med 18.02 Definitions. (1) "Emergency" means a circumstance in which there is an immediate risk to a patient's life, body part or function which demands prompt action by a physician.

(2) "Experimental treatment" means a mode of treatment which has not been generally adopted by the medical profession.

(3) "Viable" as used in s. 448.30, Stats., to modify the term, "medical modes of treatment" means modes of treatment generally considered by the medical profession to be within the scope of current, acceptable standards of care.

Med 18.03 Communication of alternate modes of treatment. (1) It is the obligation of a physician to communicate alternate viable modes of treatment to a patient. The communication shall include the nature of the recommended treatment, alternate viable treatments, and risks or complications of the proposed treatment, sufficient to allow the patient to make a prudent decision. In the communication with a patient, a physician shall take into consideration:

(a) A patient's ability to understand the information;

(b) The emotional state of a patient; and,

(c) The physical state of a patient.

(2) Nothing in sub. (1) shall be construed as preventing or limiting a physician in recommending a mode of treatment which is in his or her judgment the best treatment for a patient.

Med 18.04 Exceptions to communication of alternate modes of treatment. (1) A physician is not required to explain each procedural or prescriptive alternative inherent to a particular mode of treatment.

(2) In an emergency, a physician is not required to communicate alternate modes of treatment to a patient if failure to provide immediate treatment would be more harmful to a patient than immediate treatment.

(3) A physician is not required to communicate any mode of treatment which is not viable or which is experimental.

(4) A physician may not be held responsible for failure to inform a patient of a possible complication or benefit not generally known to reasonably well-qualified physicians in a similar medical classification.

(5) A physician may simplify or omit communication of viable modes of treatment if the communication would unduly confuse or frighten a patient or if a patient refuses to receive the communication.

Med 18.05 Recordkeeping. A physician shall indicate on a patient's medical record he or she has communicated to the patient alternate viable modes of treatment. ■

Use of consent and related forms for physicians

PREFACE. The forms referred to in this article are those which a physician may have occasion to use in his regular everyday practice. Since the forms were printed in the January 1970 "Blue Book" issue of the *Wisconsin Medical Journal*, they will not be reprinted here except for a few examples. Any physician wishing "sample" copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; or telephone 257-6781 in the Madison area or toll-free in Wisconsin 1-800-362-9080. These forms will frequently need to be adapted for a particular situation. Each physician should review them carefully before using them to make sure that they reflect the realities of a specific situation.

The forms, as printed in the January 1970 "Blue Book" issue and as listed in the box below, and the text in this article have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in January 1970.

The forms listed in the box below do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1979.* The Society attorneys suggest that any forms that a physician might wish to use outside of the forms referred to in this article be checked with the physician's personal attorney to determine their legal adequacy.

CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* PO Box 1109, Madison, Wisconsin 53701; or phone 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeard in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has a publication entitled *Consent Manual, 1981.* All member hospitals of that Association have the manual. Those forms cover hospital situations, whereas this article is concerned primarily with the physician in his regular practice.

I. WHAT IS CONSENT

Consent, in the context that we are using it, means permission from a patient or his legal representative, to a physician to diagnose and treat the patient.

a. Informed consent

To be legally valid, consent must be given by the appropriate person (see II. *Who Can Consent,* below) and this consent must be given with appropriate understanding of the nature of the treatment and the risks associated with it. This has been the law of the United States and Wisconsin for many years; and the courts have held the physician liable for treatment without proper consent, even when the treatment worked and the results were good. Treatment without consent is actionable and is the easiest form of suit against a physician because no expert testimony or evidence is needed and historically the burden has been on the physician to prove that he or she proceeded only with proper patient consent.

Under Wisconsin law you must disclose to the person giving consent such information as is necessary under the circumstances to enable a reasonable person under those circumstances to intelligently exercise his right to consent to or refuse treatment. The disclosure must be made in terms understandable to the person giving consent and need not include disclosure of matters already known to the person or risks which are extremely remote possibilities.

This rule leaves broad areas of professional judgment to the physician but requires disclosure of all matters that would be relevant to a reasonable person to permit him to make an intelligent decision to consent to or refuse the recommended treatment.

In addition recent Wisconsin statutes and administrative rules require that the patient be informed about available alternate methods of treatment. The law is as follows:

Chapter 375, Laws of 1981

AN ACT to amend 448.02(3) (intro.) and 448.40; and to create 448.30 of the statutes, relating to requiring physicians to inform their patients of alternate modes of treatment, granting rule-making authority and creating a penalty.

448.02(3) Investigation; hearing; action. (intro.) The board shall investigate allegations of unprofessional conduct by persons holding a license or certificate granted by the board. A finding by a panel established under s. 655.02 or by a court that a physician has acted negligently is an allegation of unprofessional conduct. *An allegation that a physician has violated s. 448.30 is an allegation of unprofessional conduct.* After the investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct, the board shall hold a hearing on such conduct. The board may, when it finds a person guilty of unprofessional conduct, warn or reprimand that person, or limit, suspend or revoke any license or certificate granted by the board to that person. The board shall comply with rules of procedure for such investigation, hearing and action promulgated under s. 440.03(1).

448.30 Information on alternate modes of treatment. Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
(2) Detailed technical information that in all probability a patient would not understand.
(3) Risks apparent or known to the patient.
(4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
(5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
(6) Information in cases where the patient is incapable of consenting.

Also see page 82 for complete rule on alternate modes of treatment.

The forms, as printed in January 1970, and other standard forms which you may use generally do not provide for a full description of the disclosures given, either as to treatment or risks involved. You should make some provision in your patient records to indicate specifically what disclosures were made. Some physicians tape record their disclosures and retain these tapes with the patient records. Some who are involved in the same procedure frequently use prepared statements covering the treatment and its risks and obtain receipts for copies of this information. Some give disclosures in front of witnesses and have their notes on the matters disclosed initialed or countersigned by the witnesses. For your protection you should have some record of the matters disclosed in each situation.

b. Implied consent

There are situations where the consent of the patient does not have to be in writing or even expressed orally. This is implied consent.

A classic example of implied consent is the unconscious victim of an automobile accident where immediate action needs to be taken to save the life of the patient or at least to minimize the effect of his injuries. In this emergency situation consent is im-

plied. The courts say that if the patient had been conscious he would have given consent to save his life and, therefore, the physician will not be penalized for doing what he would have been allowed to do if the patient had been conscious.

II. WHO CAN CONSENT

Persons who are adults and are competent to understand what the physician is proposing to do, why it is necessary or desirable, and what the risks of doing it are going to be, can give a consent.

a. Minors

In Wisconsin, persons under the age of 18 are minors.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless the relative has been appointed as the minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an emergency, a consent is not necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and, of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law implies the consent of the patient, or in the case of a minor, of his parent or guardian. Because the law does not imply consent beyond the treatment actually necessary to meet an emergency, the physician may safely treat only the emergency condition itself, and nothing else, without actual consent of a parent or guardian.

Second, an emancipated minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

b. Incompetents

Physicians, above all others, are qualified to determine whether a person is competent to sign a consent. If a patient is incompetent, a consent by the patient will not be any protection. For incompetents other than minors, consent can only be given by the person's legally appointed guardian, except in emergencies. Courts in Wisconsin have very limited powers to substitute their discretion for that of a person's legally appointed guardian.

c. Persons under the influence of drugs or intoxicants

Unless there is an emergency situation, the physician should either wait until the influence of the drug or intoxicant passes, or, make appropriate contacts for the appointment of a guardian. In the case of an emergency, treatment necessary to save life can be given.

III. WHY CONSENTS

In Wisconsin failure to obtain informed consent for medical treatment is the negligent violation of a legal duty. As a result of this, a physician may be sued for a species of malpractice. In other states, and under earlier case law in Wisconsin, treatment without consent was treated as a form of assault and subject to civil, and possibly criminal, liability on that basis. It is possible that in an aggravated situation, where the physician has obtained no consent or where his treatment has gone beyond the consent given, courts would still act on the assault rather than the negligence basis. In most cases, however, it should be anticipated that the question will be whether informed consent was given and failure of the physician to obtain consent based on an adequate explanation of the treatment and its possible risks is a form of negligent malpractice.

In an action for failure of informed consent, the patient has the responsibility for proving failure of disclosure by the physician, lack of knowledge by the patient of the nature of the treatment and its risks, and the adverse effects of the treatment. The physician, by way of defense, may prove reasons why no disclosure was given, these defenses to be based on the "reasonable person" rule discussed above. No expert testimony is required to assist the jury in determining whether the failure of disclosure led to consent to the treatment, or phrased another way, whether adequate disclosure would have resulted in the patient's refusing the treatment.

A few minutes spent preparing, explaining, and obtaining the consent signed by the patient and making appropriate notes in the patient records can save untold hours of time, money, and embarrassment for the physician.

IV. CONSENTS LIMITED

A word of caution needs to be set forth. A valid consent must not be too broad. It cannot be a general consent for the physician to do anything he wants to do. It should be limited to the specific situation presented by the diagnosis of the patient's illness. Finally, a consent is not effective if the treatment or procedure consented to is illegal, is contrary to public policy or, is given by a person who had no legal right to give it.

V. CONSENT AND RELATED FORMS

The text and suggestions that follow are related to the numbered forms as printed in the January 1970 "Blue Book" and as listed in the box on page 83. Physicians should read the text and suggestions prior to attempting to use or adapt a particular form.

PHYSICIAN AND PATIENT

1. Contract for services

The physician-patient contract is established when the physician, in response to an express or implied request to treat the patient, undertakes to render professional services to him. It is not necessary to have a formal written contract. The contract between the patient and physician is implied and is enforceable. If you wish, you may restrict your services to one procedure, one treatment or treatments at a particular time or place. This can be done by a letter requesting the patient to sign and return a copy to you. No form has been included for this situation. A physician need not accept every person who wishes services. He can accept patients as he wishes. Further, specialists need not accept patients who have illnesses outside their specialty.

However, once the patient-physician relationship has been entered into the physician is under an obligation to treat the patient until the relationship is terminated.

2. Termination of contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient-physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file. (These forms appear as "examples" on this page.)

b. Withdrawal from a case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

He must give the patient proper notice that he is withdrawing from the case and must give the patient

FORM 1

LETTER TO FORMER PATIENT WHERE PHYSICIAN DOES NOT WISH TO TREAT LATER ILLNESS

Dear _____:

This letter is to confirm our conversation of _____ _____ (date).

At that time I informed you that I could not accept you as a patient for your present illness. I suggested to you that you contact another physician and I urge you to do so now if you have not already done so.

Since I have treated you for a previous condition, I have records which your new physician can use. Upon receipt of your written approval, I will make available to your new physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

For your convenience I enclose a form that you may use to give me such written approval.

Very truly yours,

_____M.D.

(Enclose Form 2)

FORM 2

AUTHORIZATION TO DISCLOSE INFORMATION TO NEW PHYSICIAN

I authorize _____, M.D., my former physician, to disclose complete information to my present physician, _____, M.D., concerning medical findings and treatment from about _____ 19____ until the date of this authorization.

Signed _____

Place _____

Date_____

Witness _____

Witness _____

FORM 3

LETTER OF WITHDRAWAL FROM CASE

Dear Mr. _____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment.

Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available professionally to attend you for a reasonable time after you have received this letter, either for regular or emergency medical treatment, but in no event for more than _____ days following such receipt. This should give you ample time to select a physician of your choice from the many competent practitioners in this area.

With your written approval, I will make available to this physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

Enclosure Form 2

a reasonable amount of time to obtain a new physician. What is a reasonable amount of time will depend upon the circumstances of the case and the availability of other physicians in the area. We suggest that under most circumstances that the time set forth be not less than five (5) days. To provide a record and protect the physician a letter should be sent to the patient. If the letter is sent by certified mail with a return receipt requested, the physician will have record in his file showing not only that the patient was notified, but also the date the patient received the notification. Form 3 (example below) is appropriate for this purpose. We suggest that you may wish to enclose Form 2 with the letter for the patient's convenience.

c. Discharge of a physician

The patient may also terminate the contract by discharging the physician. The physician will want to make an immediate and adequate record that he did not abandon the patient. The physician may do well to try to obtain from the patient a signed statement of the facts and discharge of the physician. Where this is not available we suggest that the physician send a letter to the patient such as Form 4. Again, the enclosure of Form 2 is appropriate. We suggest the letter be sent by certified mail, with a return receipt requested so that your file will show receipt of the letter by the patient.

3. Special problems during treatment

There are many problems that can arise during the treatment of a patient. The ones covered in this section are of particular importance to the physician since, if no protective steps are taken and a record made of such steps, the defense against allegations of malpractice could be made considerably harder and more expensive.

a. Patient who fails to follow advice

Where a physician feels that a certain treatment or procedure should be done and the patient refuses, a record should be made. Form 5 may be adapted to the situation as it occurs.

b. Patient who fails to keep appointment

If a patient fails to keep an appointment where the patient has a condition the physician knows needs treatment, the physician should make this fact known to the patient. The physician, at the same time, should see that his records reflect his professional advice to the patient. A letter such as Form 6 should be sent to the patient.

FORM 4

LETTER TO CONFIRM DISCHARGE BY PATIENT

Dear Mr._____:

This will confirm our telephone conversation of today in which you discharged me from attending you as your physician in your present illness. In my opinion your condition requires continued medical treatment by a physician. If you have not already done so, I suggest that you employ another physician without delay. You may be assured that, at your written request, I will furnish him with complete information regarding all medical facts, diagnosis, and treatment which you have received from me.

Very truly yours,

_____, M.D.

Enclosure Form 2

FORM 5

LETTER TO PATIENT WHO FAILS TO FOLLOW ADVICE

Dear Mr. _____:

At the time that you brought your son, William, to me for examination this afternoon, I informed you that I was unable to determine, without X-ray pictures, whether a fracture existed in his injured right arm. Although I insisted and still do insist that an X-ray study should be made of William's arm, you have refused to follow my advice. I strongly urge you to permit me or some other physician of your choice to make this X-ray examination without further delay.

Your refusal to permit a proper X-ray examination to be made of William's arm may result in serious consequences if, in fact, a fracture does exist.

Very truly yours,

_____, M.D.

FORM 6

LETTER TO PATIENT WHO FAILS TO KEEP APPOINTMENT

Dear Mr. _____:

On _____, 19_____, you failed to keep your appointment at my office. In my opinion your condition requires continued medical treatment. If you so desire, you may telephone me for another appointment, but if you prefer to have another physician attend you, I suggest that you arrange to do so without delay. You may be assured that, at your request, I am entirely willing to make available my knowledge of your case.

I trust that you will understand that my purpose in writing this letter is out of concern for your health and well-being.

Very truly yours,

_____, M.D.

c. Patient who leaves hospital against medical advice

Cases arise where patients refuse to remain in a hospital even though their physician feels that continued hospitalization is necessary. Form 7 (example below) provides a statement that the patient may sign which will release liability for the patient's acts. The physician should have two witnesses with him at the time he informs the patient of the reasons the physician feels indicate the need for continued hospitalization. These witnesses should sign the form whether the patient signs the form or not. If the patient refuses to sign, that fact should be noted on the form. The physician should have a copy of the form for his office records. The hospital will also want a copy for its records.

d. Substitute physician in obstetrical cases

It is not unusual for a physician to be unable to be present at a delivery, even though the physician would wish to be there. Another delivery might be in progress or the speed of delivery might make it impossible for the physician to get to the place of delivery. The physician should explain this to his obstetrical patient when she first comes to his offfice. The physician should have the expectant mother sign a form such as Form 8 as an acknowledgment of the fact that she understands and agrees.

FORM 7

STATEMENT OF PATIENT LEAVING HOSPITAL AGAINST MEDICAL ADVICE

This is to certify that I am leaving _____ Hospital at my own insistence and against the advice of my attending physician and hospital authorities. I have been informed by them of the dangers attendant on my leaving the hospital at this time. I assume all responsibility for any results caused by leaving the hospital prematurely, and I hereby release my attending physician and the hospital, its employees and officers from all liability for any and all conditions, complications and results.

_____

I hereby agree to hold harmless my attending physician and the _____ Hospital, its employees and officers, from all liability of whatsoever nature, with reference to the discharge of the patient named above.

_____
(husband, wife, parent, etc.)

Date _____
Signed in the presence of:
Witness _____
Witness _____

NOTE: If the patient refuses to sign such a statement, he cannot be forced to do so, legally, nor may his release be withheld until he signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement made on the form "signature refused."

e. Office treatment

Some procedures can be done either in the physician's office or in the hospital. Where the physician decides to do the procedure in his office he should inform the patient of the alternatives and any special risks involved. If the patient decides that the procedure should be done in the hospital, the physician should not attempt to do the procedure in his office. If the patient does agree to having the procedure in the office, then the physician should have the patient sign a consent such as Form 9.

4. Confidential and privileged relationship

In Wisconsin, communications between a patient and his physician are protected both by law and ethics.

Under Wisconsin law, certain disclosures made by a patient to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Wisconsin Statutes permit the right of an employee or the employee's designated representative to

FORM 8

PROVISION FOR SUBSTITUTE PHYSICIAN AT DELIVERY

Date _____
Place _____

To Dr. _____:

In engaging you as my obstetrician, I understand that if you are unavailable or unable for any reason to be present and to deliver me, at the time of my confinement, you will make a reasonable effort to refer me to another duly licensed physician to render obstetrical care. I agree to hold you free from any duty, liability or responsibility in connection with any services that may be performed by any physician to whom you refer me or whom I may call.

Signed _____
(wife)

_____
(husband)

Signed in the presence of:
Witness _____
Witness _____

NOTE: If the husband is present at the time that the arrangements are made, it is desirable that he should witness his wife's execution of this form and sign the form too.

inspect personal medical records concerning the employee contained in the employer's file. If the employer believes that disclosure of an employee's medical records would have a detrimental effect on the employee, the employer may release the medical records to the employee's physician or through a physician designated by the employee, in which case the physician may release the medical records to the employee's immediate family.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

a. Release of patient health care records

By earlier case law and now by statute, a patient's health care records (all records related to the health of a patient prepared by or under the supervision of a health care provider) may ordinarily only be released on the authorization of the patient or one legally permitted to act for the patient. The law defines "informed consent" with respect to the disclosure of information from a patient as written consent "containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the type of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective." Wis. Stats. §146.81 (2). In making a release of medical records, the physician should very carefully review the authorization to assure that the release is made strictly in accordance with the authorization.

(1) Access without informed consent. Release of medical records without patient authorization, unless specifically permitted by law, is a breach of confidentiality and may subject the physician to a lawsuit. The law permits the release of patient health care records upon request without informed consent in the following circumstances:

(a) To staff, accreditation or review committees.

(b) For performance of healthcare services to persons providing such services (including emergency care) or being consulted in regard to such services.

(c) For billing, collection, and payment of claims.

(d) Under court order.

(e) On written request from an appropriate government agency.

(f) For research purposes under specific conditions.

(2) Patient access to health care records. Any patient or other person may, upon submitting a statement of informed consent, (a) inspect the patient's records during regular business hours upon reasonable notice, (b) receive a copy of the patient's records on payment of reasonable costs, (c) receive a copy of the patient's x-ray reports or have the patient's x-ray films referred to a provider of his choice for analysis upon payment of reasonable costs. Wis. Stats. §146.83.

b. Photographs

Physicians may wish to make a visual record of a case for several reasons. In cosmetic surgery it may show the result of the surgery. In other cases it may show the result of a particular method of treatment. It may also be used for unusual cases where documentation would be valuable for teaching purposes. In any of these cases there must be a release of the confidential or privileged relationship to allow the taking of photographs.

c. Observers, motion pictures, television

In cases similar to those where photographs may be desirable, there are cases which should be observed, televised or recorded on film. The release of the confidential or privileged relationship must also be obtained in these cases. Forms 13, 14 and 15 may be used for these situations.

VI. SPECIAL SITUATIONS

There are certain procedures which the physician should approach with caution and be sure to take the necessary steps to document what has happened and, to be sure that he proceeds only with proper authority and consent. These include:

1. **Abortions**
2. **Artificial insemination**
   - *a. Homologous*
   - *b. Donor*
3. **Sterilization**
   - *a. Sterilization as a result of an operation for other purposes*
   - *b. Therapeutic sterilization*
   - *c. Nontherapeutic sterilization*

VII. OTHER CONSENT FORMS

There are other forms included in the January 1970 "Blue Book" printing that may be of common use to a physician. These forms are believed not to require explanatory text. However, before any of these forms are signed, the physician should review the requirements for a valid consent given earlier in this article. ■

Must a Wisconsin physician report . . .

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.
i. When a physician cannot be obtained within 24 hours of death.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Lead poisoning?

Yes, within 48 hours to the DHSS or local health officer.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Department of Health and Social Services. Results of required metabolic disorder tests need not be reported by physicians but positive test results must be reported by the State Laboratory of Hygiene.

11. Communicable diseases?

Yes, to local health officers.

12. Sexually transmitted diseases?

Yes, to the local health officers.

13. Tuberculosis?

Yes, to local health officers.

14. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

15. Epileptics?

No, but see item in article "SMS members, you should know. . ." elsewhere in this issue.

16. Drug addiction?

No.

17. Abused or neglected children?

Yes. The law requires reports of "abused" (including sexual exploitation and "emotional damage") or "neglected" (those not receiving food, clothing, shelter or care, including medical care so as to "seriously endanger" the child's health) children, children threatened with injury, or those with exceptional educational needs. Wilful failure to report may subject a physician to a penalty; good faith reports provide immunity.

18. Cancer?

No, but hospitals are required to report to the Department of Health and Social Services.

19. Abused elderly persons?

No, but any person with reasonable facts indicating physical or financial abuse, neglect or self-neglect of a person age 60 or older or who is subject to the infirmities of aging may report this to the agency designated by the county board to receive such reports.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, *except* as specifically required or authorized by law, any information which he or she acquired in attending a patient and which is necessary for him or her to treat that patient. Information provided to the Department of Health and Social Services which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient. Address: DHSS, 1 W Wilson St, PO Box 309, Madison, WI 53701.

MEDICAL EXAMINING BOARD—Chapter Med 10

UNPROFESSIONAL CONDUCT DEFINED

Med 10.01 Authority and purpose. The definitions of this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.08, and 448.40, Stats., for the purposes of ch. 448, Stats.

Med 10.02 Definitions. (1) For the purposes of these rules:

(a) "Board" means the medical examining board.

(b) "License" means any license, permit, certificate, or registration issued by the board.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(a) Violating or attempting to violate any provision or term of chapter 448 of the statutes or of any valid rule of the board.

(b) Violating or attempting to violate any term, provision, or condition of any order of the board.

(c) Knowingly making or presenting or causing to be made or presented any false, fraudulent, or forged statement, writing, certificate, diploma, or other thing in connection with any application for license.

(d) Practicing fraud, forgery, deception, collusion, or conspiracy in connection with any examination for license.

(e) Giving, selling, buying, bartering, or attempting to give, sell, buy, or barter any license.

(f) Engaging or attempting to engage in practice under any license under any given name or surname other than that under which originally licensed or registered to practice in this or any other state. This subsection does not apply to change of name resulting from marriage, divorce, or order by a court of record.

(g) Engaging or attempting to engage in the unlawful practice of medicine and surgery or treating the sick.

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

(i) Practicing or attempting to practice under any license when unable to do so with reasonable skill and safety to patients.

(j) Practicing or attempting to practice under any license beyond the scope of that license.

(k) Offering, undertaking, or agreeing to treat or cure a disease or condition by a secret means, method, device, or instrumentality; or refusing to divulge to the board upon demand the means, method, device, or instrumentality used in the treatment of a disease or condition.

(l) Representing that a manifestly incurable disease or condition can be or will be permanently cured; or that a curable disease or condition can be cured within a stated time, if such is not the fact.

(m) Knowingly making any false statement, written or oral, in practicing under any license, with fraudulent intent; or obtaining or attempting to obtain any professional fee or compensation of any form by fraud or deceit.

(n) Wilfully divulging a privileged communication or confidence entrusted by a patient or deficiencies in the character of patients observed in the course of professional attendance, unless lawfully required to do so.

(o) Soliciting or attempting to solicit patients, directly, indirectly, or by agents.

(p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 161.01 (4), Stats. otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(q) Having a license, certificate, permit, or registration granted by another state to practice medicine and surgery or treat the sick limited, restricted, suspended, or revoked, or having been subject to other disciplinary action by the licensing authority thereof.

(r) Conviction of any crime which may relate to practice under any license, or of violation of any federal or state law regulating the possession, distribution, or use of controlled substances as defined in s. 161.01 (4), Stats. A certified copy of a judgment of a court of record showing such conviction, within this state or without, shall be presumptive evidence thereof.

(s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch. 161 Stats. to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun. ■

Some considerations before opening a physician's practice

WHEN BEGINNING a medical practice, whether starting a new one or joining an existing group, there are many matters that should be considered before seeing your first patient. The following check list has been developed to itemize major tasks or decisions a physician should consider prior to that time. Depending upon the type of practice, some may not apply; however, if this list is used, the majority of items will be covered.

- ☐ *Discuss practice location with spouse* (type of community desired, location, size, hospitals, school system, cultural opportunities).
- ☐ *Office facilities* (rent—negotiate lease; own—negotiate and close purchase).
- ☐ *Determine office layout and size.*
- ☐ *Furniture and equipment* (office—chairs, desks, calculators, computer; waiting room—chairs, tables, lamps; examining room—desk, chairs, exam table, medical equipment and supplies).
- ☐ *Obtain license to practice medicine.*
- ☐ *Obtain federal narcotics number.*
- ☐ *Develop employment contract.*
- ☐ *Partnership agreement or service corporation articles.*
- ☐ *Hospital staff privileges.*
- ☐ *Choose advisors* (accountant, lawyer, banker, management consultant, insurance agent, real estate broker, investment counsel).
- ☐ *Obtain necessary insurance coverage* (business—professional liability, Worker's Compensation, general liability, umbrella [business/personal], employee fidelity bond; personal—health, life, disability income/income protection, home owners, auto).
- ☐ *Determine office hours based on community needs.*
- ☐ *Apply for federal and state employer identification (ID) numbers.*
- ☐ *Apply for federal and state unemployment compensation tax ID numbers.*
- ☐ *Determine support staff needed, interview and hire.*
- ☐ *Obtain necessary financing.*
- ☐ *Develop financial systems* (determine fees, accounting system, billing, system, statement format, collections and receivable management, consider credit card payments by patients, internal controls).
- ☐ *Announcements to local physicians, pharmacists, general public* via newspaper, telephone directory, individually mailed announcements and calling and appointment cards.
- ☐ *Open checking account(s).*
- ☐ *Learn community resources* (hospitals, schools, pharmacies, social services, rehabilitation services).
- ☐ *Arrange for utilities* (telephone, electricity, gas/oil, water).
- ☐ *Telephone answering service.*
- ☐ *Arrange for coverage during off hours.*
- ☐ *Order necessary office forms* (letterhead, envelopes, RX forms, accounts receivable statements, third-party claim forms or uniform claim forms).
- ☐ *Arrange for lab and x-ray services.*
- ☐ *Obtain good debt collection service.*
- ☐ *Repay student loans on timely basis.*
- ☐ *All employees must complete federal Form W-4 and state Form WT-4* (withholding allowance certificates).
- ☐ *Memberships* (become involved in: county and state medical societies, AMA, specialty societies, local service or business groups, hospital staff activities).

The AMA has a regular schedule of "Starting Your Own Practice" workshops which also provide much information on this subject.

This checklist is intended to provide the most common matters a physician should consider when starting a practice. It is not inclusive in every instance since individual circumstances require attention to matters unique to that situation.

Physicians may also contact the State Medical Society in Madison for additional information: (608)257-6781, or toll-free in Wisconsin 1-800-362-9080. Office location: 330 East Lakeside St, Madison 53715 (Lakeside Street intersects John Nolen Drive at the signal lights just before crossing the "causeway" over Lake Monona to Downtown Madison, from the South Beltline near the Coliseum).

"Blue Book" good reference source

Whether opening a practice for the first time or moving a practice to Wisconsin, physicians will find valuable information in the annual "Blue Book" issue of the *Wisconsin Medical Journal,* the official publication of the State Medical Society of Wisconsin. This is a reference source on medicolegal, socioeconomic, legislative, governmental matters of direct concern to the physician. It also is a reference source on State Medical Society organizational structure, other related organizations, and state government agencies.

To obtain a copy contact the *Wisconsin Medical Journal,* PO Box 1109, Madison, Wis 53701, or phone State Medical Society offices in Madison as noted above. ■

Some considerations in the closing of a physician's practice

WHILE THERE ARE NO formally slated rules for closing a medical practice, there are several important items which should be considered and planned in advance. The list given below is not complete but the State Medical Society of Wisconsin believes it will be helpful.

1. Notification of patients

Patients should be given adequate notice, a minimum of three months is suggested, in writing that you plan to close your office and on what date so that they will have sufficient time to obtain another physician. It is also suggested that, in the letter of notice to the patients, you enclose a form for the patient to sign authorizing the release of records should they wish to request that a copy of their records be sent to the new physician of their choice. A list of all patients notified should be retained in your files.

You can save postage, in the case of current patients, by inserting the letter with a monthly statement or billing; letters to other patients will have to be mailed separately.

You also may wish to place an announcement in one or more local newspapers.

2. Retention of medical records

(a) Medical records, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others, should not be destroyed until the statute of limitations has expired with regard to each patient. This is because the physician's record and liability insurance policies could be your chief source of defense in a future law suit.

The Statute of Limitations has been revised to allow actions involving adults to be initiated within three years of the occurrence or one year from discovery of the injury but not later than five years from the occurrence. Actions involving minors are bound by this limitation, or age 10 years, whichever is later. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

(b) The patient has a general right to know what is in his medical records and thus you should make it known where such records can be obtained. Such records generally should not be given to the patient, but should be forwarded to another physician of the patient's choice with the consent and at the request of the patient, in writing.

(c) The Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization read:

"**804.10 (4).** Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

3. Disposal of drug stocks

The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, Post Office Box 28083, Central Station, Washington, D.C. 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Avenue, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

Instructions on the disposal of non-narcotic drugs in the possession of the physician may be obtained from the Wisconsin Pharmacy Examining Board, 1400 East Washington Avenue, Madison, Wisconsin 53702.

4. Sale of medical practice

(a) If you are selling your practice, you should make certain that the buyer is a physician licensed, or eligible to be licensed, in Wisconsin. This information can be obtained from the State Medical Society or the Wisconsin Department of Regulation and Licensing.

(b) Records relating to patients should not be sold. However, the sale may include, as one of its terms,

unlimited access to the records of those patients who seek the services of the purchasing physician.

5. Keeping your license in force

You may wish to keep your license in force and register each year in the event that you wish to do some consultation work or are called upon to perform some act of medical practice in an emergency. If you elect to keep your license in force, you will be required to continue to meet the continuing medical education requirements. This requirement calls for 30 hours of Category I credit as defined in the Physician's Recognition Award of the American Medical Association, to be accumulated every two years. The Medical Examining Board requires this regardless of extent or nature of practice; there are no exceptions due to age or retirement.

6. Malpractice insurance

Your policy should be examined to determine whether it is written on a CLAIMS INCURRED or a CLAIMS MADE basis. Consult your insurance agent. If the policy is written on a CLAIMS MADE basis, only those claims made while the policy is in force will be covered and you should either continue your coverage or purchase coverage extension to protect you until all statutes of limitation have run.

7. Accounts receivable

Not all of your patients will have paid their bills by the time your practice is closed. It will be necessary to have someone available to accept, record, and deposit payments received after the official closing of your practice. You may wish, after a suitable waiting period of three or four months, to turn those accounts still unpaid over to a reputable collection agency.

8. Continuation of SMS membership

We hope that you will continue to be active in organized medicine. The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that an appropriate change in classification can be arranged.

9. Income taxes

Copies of your income tax returns and all supporting documentation, including ledgers and accounting records, should be preserved until the Internal Revenue Service can no longer assess additional tax. For Federal returns filed on time and containing all correct and pertinent data, this is usually three years; for returns where gross income has been understated by 20 percent or more, it is six years; for fraudulent returns or where no return has been filed there is no time limit.

10. Payroll taxes

Final returns and payments of all Federal and state withholding and Social Security taxes must be made after the last employee has been terminated and the last payroll paid.

Finally, it is recommended that you work closely with your attorney or business manager particularly on the tax aspects of closing your practice. ■

Problems of a physician's widow/er

FOLLOWING THE LOSS of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow/er in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow/er. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow/er will be faced with many decisions involving the settlement of the business affairs relating to the late husband's or wife's practice. It is of extreme importance that she/he act upon the advice of an attorney. When practical it is recommended that the physician acquaint his/her spouse with his/her legal and other advisors and some of his/her business affairs. This will provide an established working business relationship between the spouse and the advisors for that eventuality when she/he is called upon to act. Some of the chief problem areas the widow/er will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow/er also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

"The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P.O. Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Ave., Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

It is important that a widow/er, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his/her death may be obtained from the Wisconsin Pharmacy Examining Board, 1400 E Washington Ave, Madison, Wis 53702.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow/er's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow/er can expect that the deceased physician's patient will seek care elsewhere unless he/she had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his/her patient. In such event, it is wise to insist upon a written request from the patient and his/her new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow/er should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow/er's legal and other advisors can best inform her/him how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. The widow/er should carefully follow her/his attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow/er or the heirs to enforce collection by suit within such period. She/he should also seek legal and accounting advice on how long to retain the financial records of her/his late spouse. It is quite possible that his/her estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A widow/er should consult her/his attorney as to whether the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the widow/er's share of such assets. Some physicians will have attempted to do this during lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a widow/er, the family, or the estate attorney.■

Liability for malpractice and some other claims do not cease upon the death of a physician. Liability suits can be quite traumatic for the surviving spouse, especially if they should occur shortly after the physician's death. Some insurance company-appointed attorneys have been known to provide little advice or counseling to surviving spouses who in a state of bereavement may be fearful of attorneys whom they have never known before. Should surviving spouses have questions concerning liability matters, they are urged to contact the State Medical Society.

Important notice to physicians and clinics re toxic substances and infectious agents

Every employer of one or more persons in Wisconsin is required to post a notice to employees indicating that the employer will provide upon request information about toxic substances and infectious agents which might be found in the workplace. This law became effective December 1, 1982. SMS recommends that every physician/clinic cut out the poster accompanying this article and make sure it is displayed where employees can see it.

This will assure initial compliance with the law. If an employee makes a written request, the employer must provide that individual with information about any toxic substance the employee is likely to be exposed to in the workplace. The information which must be provided includes the name of the toxic substance or infectious agent, a description of their hazardous effects, precautions for handling such substances or agents, and procedures for emergency treatment in event of overexposure. The posted form must indicate the name of a person who should be contacted to make such a request.

For toxic substances, the employer must provide this information within 15 working days of a written request by an employee. For infectious agents, the information must be provided to the employee within 3 working days. Employers who do not have the required information available for either toxic substances or infectious agents have 30 working days to obtain such information and provide it to the employee. The information must be requested from the manufacturer or supplier. If they refuse to provide the information, the employer is not required to provide the information for the requesting employee.

A toxic or hazardous substance is defined by law as "any substance regulated by the federal regulations part 1910, subpart z, which are introduced by an employer . . . in the workplace." The list of these substances can be obtained from the SMS or the Department of Industry, Labor and Human Relations (DILHR) at the address shown on the poster.

Information of the type that must be provided to the employee about toxic or hazardous substances must be obtained from the supplier or manufacturer of the material. The physician or clinic purchase order for materials which may contain hazardous or toxic substances should be accompanied by a "Material Safety Data Sheet" or its equivalent. This sheet makes it a condition of the purchase order that the vendor will supply the physician or clinic with material related to the safe use of its product and will identify all hazardous components. Copies of the data sheet are available from the SMS and DILHR. Under the law a supplier or manufacturer may refuse to provide such information on the basis of confidentiality. The employer must be sure to get such refusal in writing. Once that written statement is provided, the employer is no longer required to make further efforts to obtain the information.

Infectious agents are defined as any bacterial, mycoplasmal, fungal, parasitic or viral agent identified by DILHR by administrative rule which causes illness in humans, human fetuses or both, which is ***introduced into the workplace by the employer.*** Infectious agents do not include agents on or in the body of a person who is present in the workplace for diagnosis or treatment. NOTE: Until DILHR publishes rules identifying these agents, this section of the law is not enforceable. At the time of this publication DILHR had not yet published this rule.

The law also requires that training sessions must be held for employees exposed to such substances so as to provide them with information about the substances or agents, symptoms and effects of overexposure, the potential for flammability, explosion and reactivity, proper conditions for safe use of the substances or agents, special precautions to be taken or personal protective equipment to be used when handling them, and procedures for handling cleanups or spills. Training sessions may take almost any form, but it is important that the employer have employees sign a statement indicating that they have received the prescribed training. The penalties for noncompliance are a civil forfeiture of not more than $1,000 for each violation and forfeiture of up to $10,000 per violation for those who "willfully violate or exhibit a pattern of violation." Enforcement is through the local district attorney.

For additional questions/answers about this law, contact Deb Powers at SMS headquarters (telephone: 1-800-362-9080 or in Madison 257-6781), or Jack Borders at DILHR, PO Box 7969, Madison, WI 53707, telephone: 608/266-7731.■

Wisconsin Clearinghouse

A state agency for information on alcohol and other mood-altering drugs, primary prevention, mental health, and other health topics.

The Wisconsin Clearinghouse is a state agency for information on alcohol and other mood-altering drugs, primary prevention, mental health, and other health topics.

Housed by the University of Wisconsin-Madison, the Clearinghouse offers many publications which are suitable for patient information as well as for professional reference. Dozens of these are available at no cost to Wisconsin residents, except for shipping and handling, and a separate catalog lists over 30 other publications available for purchase. Some of the items are produced by Clearinghouse staff, while others are provided by the Wisconsin Office on Alcohol and Other Drug Abuse, the National Institute on Drug Abuse, the Addiction Research Foundation and other organizations.

In addition to pamphlets, books, professional manuals, public awareness kits and curricula, the Clearinghouse offers many colorful posters aimed at people of many ages and interests. Also available are video tapes on marijuana, caffeine, and the dangers of chemicals unknown to children. The Clearinghouse staff also evaluates films and publications from other sources. Synopses, ratings, and other information on these resources are available on request.

Wisconsin Clearinghouse office hours are 8:30 am —4:45 pm Monday-Friday, although publications may be ordered by mail or telephone. For more information contact Wisconsin Clearinghouse, 1954 E Washington Ave, Madison, WI 53704 (608-263-2797). ■

NARCOTICS

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The initial registration application may be obtained from the Chicago Regional Office. The Regional Office of DEA in Chicago has informed the State Medical Society that DEA Headquarters will then annually mail a renewal application to each physician once initially registered.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 500, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office:

Drug Enforcement Administration
Milwaukee District Office
517 East Wisconsin Ave, Rm 228A
Milwaukee, Wisconsin 53202

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks. ■

Attending physician's return-to-work recommendations record

Edward P Horvath Jr, MD, Marshfield, Wisconsin
James J Andonian, MD, Madison, Wisconsin
Donald M Rowe, MD, Kohler, Wisconsin

PERIODIC MEETINGS have been conducted between physicians and industry representatives through the State Medical Society's Liaison Committee on Health Care Costs. One of the first subjects raised by employers was the return-to-work issue. Considering the lost productivity and escalating costs from both work-related and nonoccupational disorders, it is not surprising why this was a major focus of management. Physicians have a similar concern, albeit for somewhat different reasons. Clinicians have long recognized the beneficial psychologic and physical effects which accrue to most patients by shortening the convalescent period. Of course, any resumption of activity must be consistent with the patient's temporary or permanent restrictions.

The Liaison Committee on Health Care Costs and the Society's Committee on Environmental and Occupational Health believe physicians have a responsibility to cooperate with industry in facilitating their patients' return to work. Employers are entitled to counsel about medical fitness of individuals in relation to work. On occasion, more specific details of the patient's condition, including the diagnosis itself, also may need to be discussed. Signed authorization release is necessary in the latter circumstance and is advisable in the former as well. Having been provided with the necessary medical information by the physician, the employer can then attempt to identify a job which matches the worker's restrictions.

The return-to-work form, shown on opposite page, should facilitate this process. It was independently developed by several individuals including interested medical and industrial groups. It has subsequently been adopted by several county medical societies and undergone slight modifications in content. All reports on its use thus far have been favorable.

The Society's Committee on Environmental and Occupational Health and the Liaison Committee on Health Care Costs have reviewed and endorsed this form. While recognizing that it is not all-inclusive, it does provide the attending physician with functional guidelines for return-to-work recommendations. A narrative section is available for the physician to explain special limitations such as temperature extremes, contact with skin irritants, and visual and hearing problems. A space for authorization release by the patient is provided and must be signed in circumstances where specific medical information such as the diagnosis is given.

Both Society committees recently unanimously recommended its use by Wisconsin physicians, and the form has been submitted for national consideration through the American Medical Association and the American Occupational Medicine Association. The form is not copyrighted and may be reproduced without restrictions. However, the SMS Services, Inc has printed the form in 3-part sets, and these sets are available to Society members upon request to: Return-to-work Form, SMS Services, Inc, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area); toll-free in Wisconsin (800) 362-9080. ■

Alcoholics Anonymous

The State Medical Society's Committee on Alcohol and Other Drug Abuse recommends that physicians be aware of the Central Offices of Alcoholics Anonymous as a support group in the care of their patients.

Green Bay 414-437-9971	Milwaukee 414-272-3081
Kenosha 414-654-8246	Superior-Duluth 218-728-5572
Madison 608-222-8989	La Crosse 608-784-7560

It should be emphasized, however, that patients should make the call to the Central Office because Alcoholics Anonymous cannot be of assistance unless the patient wants help.

Each of these Central Offices has a list of recovering alcoholics who will call the patient and offer help. If there is no Central Office listed in an area, patients should check the local phone book under Alcoholics Anonymous. Often a local phone number will be listed where there is no Central Office. ■

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Company Name

Patient's Name (Last) (First) (Middle Initial) | Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN—PLEASE CHECK

DIAGNOSIS/CONDITION (Brief Explanation)

I saw and treated this patient on _____ (Date) and based on the above description of the patient's current medical problem:

1. ☐ Recommend his/her return to work with no limitations on _____ (Date).
2. ☐ He/She may return to work on _____ (Date) with the following limitations:

CHECK ONLY AS RELATES TO ABOVE CONDITIONS

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Light Heavy Work.** Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand/Walk
      ☐ None ☐ 4-6 Hours
      ☐ 1-4 Hours ☐ 6-8 Hours
   b. Sit
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours
   c. Drive
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours
2. Patient may use hand(s) for repetitive:
   ☐ Single Grasping ☐ Pushing & Pulling
   ☐ Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No
4. Patient may:

	Not At All	Occasionally	Frequently
a. Bend	☐	☐	☐
b. Twist	☐	☐	☐
c. Squat	☐	☐	☐
d. Climb	☐	☐	☐
e. Reach	☐	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS

3. ☐ These restrictions are in effect until _____ (Date) or until patient is reevaluated on _____ (Date).
4. He/she is totally incapacitated at this time. Patient will be reevaluated on _____ (Date).
5. Referred To: ☐ None ☐ Private physician _____ (Doctor)
   ☐ Return Here _____ (Date & Time) ☐ A Consultant _____ (Doctor, Date & Time)

Physician's Signature | Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or his representative.

Patient's Signature | Date

STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program

for Continuing Medical Education

INFORMATION IS AVAILABLE in printed form from either Bill Wendle, Scientific Affairs Coordinator, or Arlene Meyer, Administrative Assistant, Continuing Medical Education, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; or telephone toll-free in Wisconsin 1-800-362-9080 (Madison area: 257-6781).

Representatives of the American Medical Association took the initiative to bring about the unification of a body responsible for accreditation of continuing medical education. This effort resulted in the adoption by the AMA House of Delegates at its Interim Meeting in December 1980 of the report of the Board of Trustees recommending the creation of the Accreditation Council for Continuing Medical Education (ACCME) and the bylaws for this new organization (which became operational January 1, 1981) and assumed the responsibility for national accreditation of organizations, institutions, and agencies offering continuing medical education. The state medical associations will retain the responsibility for accreditation of intrastate continuing medical education in accordance with the agreements reached in the creation of ACCME as stated in its bylaws.

The State Medical Society of Wisconsin's accreditation program functions under the authority of the AMA's newly created Accreditation Council for Continuing Medical Education (ACCME). Representatives from state medical societies, national medical specialty societies, AMA Section on Medical Schools and Resident Physician's Section, National Medical Association, American Hospital Association, Association for Hospital Medical Education, Federation of State Medical Boards, and medical specialty boards comprise the ACCME.

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CAREGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical teaching.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

continued on opposite page

CME Accreditation Program/*continued*

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED *by SMSW and ACCME for continuing medical education programming at January 1, 1985*

Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Eagle River Memorial Hospital, Eagle River
Family Hospital, Milwaukee
Ft Atkinson Memorial Hospital, Ft Atkinson
Good Samaritan (Lutheran) Medical Center, Milwaukee
Gundersen Medical Foundation Ltd and La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital of Oconomowoc, Oconomowoc
Mercy Hospital, Janesville
Mercy Medical Center, Oshkosh
Methodist Hospital, Madison
Mount Sinai Medical Center, Milwaukee
Osseo Area Municipal Hospital, Osseo
Reedsburg Memorial Hospital, Reedsburg
Riverside Community Hospital, Waupaca
Sacred Heart Hospital, Eau Claire
Sacred Heart/St Mary's Hospitals, Inc, Rhinelander
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial & St Nicholas Hospitals, Sheboygan
St Agnes Hospital, Fond du Lac
St Alphonsus Hospital, Port Washington
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Hospital, Milwaukee
St Francis Hospital, La Crosse
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital. Milwaukee
St. Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Marys Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point
St Vincent Hospital, Green Bay
Stoughton Hospital Association, Stoughton
Theda Clark Memorial Hospital, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Medical Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

* * *

American Cancer Society, Wisconsin Affiliate
American Heart Association, Wisconsin Affiliate
Arthritis Foundation: Wisconsin Chapter
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
The Racine Academy of Medicine
Wisconsin Academy of Family Physicians
Wisconsin Academy of Ophthalmology
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Otolaryngology —Head and Neck Surgery
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

* * *

Marinette-Florence County Medical Society

* * *

ACCME Accredited
Dept CME, Medical College of Wisconsin
Dept CME, UW Center for Health Sciences
Interstate Postgraduate Medical Association
State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

Charter Law of Medical Societies

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13; Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ■

1841—The Society created by territorial legislation

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . .well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . .a society under the name and style of the Medical Society of the Territory of Wisconsin. ." Drs. Bushnell B. Cary, M.C. Darling, Lucius L. Barber, Oliver E. Strong, Edward McSherry, E.W. Wolcott, J.C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B.O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

CONSTITUTION AND BYLAWS
of the State Medical Society of Wisconsin

CONSTITUTION

ARTICLE I
Name of the Association

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution or Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

ARTICLE III
Component Societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

ARTICLE IV
Composition of the Association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided in the Bylaws.

ARTICLE V
House of Delegates

The House of Delegates shall be the legislative body of the Society, and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote.

The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty section.

ARTICLE VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum.

Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district, except that in any district with 200 or more regular and special members, there shall be elected one additional director for each additional 200 members or majority fraction thereof. As nearly as possible, one-third of the members of the Board shall be elected each year.

Each director shall be nominated and elected only by the elected delegates of the county medical society or societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates.

The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

ARTICLE VII
Specialty Sections

The House of Delegates shall provide for a division of the Society into specialty sections.

ARTICLE VIII
Meetings

Section 1. The Society shall hold an Annual Meeting, at which time the House of Delegates shall meet to conduct its business. The Annual Meeting may also include scientific sessions as determined by the Board.

Sec. 2. The place for holding each Annual Meeting shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Board. The time for holding each Annual Meeting shall be approved by the Board.

Sec. 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

ARTICLE IX
Officers

Officers of this Society shall be a president, a president-elect, a secretary, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The secretary shall be elected annually by the Board. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect.

Adopted as amended by the House of Delegates March 24-25, 1983.

The treasurer shall be limited to nine consecutive terms.

No person shall hold more than one of the following offices concurrently: president, president-elect, secretary, treasurer, speaker, vice speaker, director. Incumbents shall serve until their successors are elected and installed.

ARTICLE X
Funds and Expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class.

All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

ARTICLE XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

ARTICLE XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any Annual Meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous Annual Meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be *prima facie* evidence of membership and of the right to benefits.

Sec. 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec. 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec. 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec. 5. A member of a component society whose license has been revoked, suspended, nonrenewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, nonrenewal, or voluntary surrender, pending definitive action by the Board.

Sec. 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec. 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec. 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec. 9. *Membership Classifications.* Members defined in this section, except Affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B. (5), may upon application, recommendation by the

county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec. 10. *Dues and Assessments.* Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* one-tenth of regular member dues and assessments.

Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

CHAPTER II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society.

For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled.

The secretary of each county society will send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec. 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec. 3. The speaker shall preside at the meetings of the House of Delegates.

Sec. 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec. 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec. 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec. 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec. 8. It shall receive for appropriate action the annual reports of the treasurer, secretary, and chairman of the Board of Directors.

Sec. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec. 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

CHAPTER III
Annual Election

Section 1. The House of Delegates, at its first session of the Annual Meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except

that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. This committee shall become operative at the close of the final session of that Annual Meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the Annual Meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot from among the section delegates.

The Committee on Nominations shall convene at least two (2) months prior to the Annual Meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the positions to be filled.

Sec. 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the Annual Meeting.

Sec. 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER IV
Duties of Officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. Deliver an annual address to the House;
b. Serve as a member with right to vote on the Board;
c. Preside at meetings of the Executive Committee of the Board;
d. Participate, ex officio and without the right to vote, in sessions of the House;
e. Initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. Support and articulate policies and programs adopted by the Board and the House;
g. Promote physician interest and active participation in the Society.

Sec. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec. 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.

Sec. 4. The secretary is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. Duties of the secretary shall include being secretary of and responsible to the Board; assisting the officers in making decisions and implementing actions; sharing convictions and arguing their merits as requested. Duties as chief executive officer shall be:

a. Assume the general managerial duties of all Society divisons, activities, and personnel;
b. Be custodian of all records and papers belonging to the Society, except such as properly belong to the treasurer;
c. Keep account of and promptly turn over to the treasurer all funds of the Society which come into the secretary;
d. Maintain current copies of each component county society's constitution and bylaws;
e. Conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointments and duties;
f. With the approval of the Board, employ such assistants as are needed to effectively execute the policies of the Society;
g. Make an annual report to the House of Delegates.

CHAPTER V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec. 2. The Board shall meet during the Annual Meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec. 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the

House of Delegates including all major actions and policy decisions of the preceding year.

Sec. 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the Annual Meeting of the Society.

Sec. 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board.

The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions.

The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec. 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec. 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec. 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec. 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified.

When a district initially qualifies for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec. 11. The Board may elect as secretary one who need not be a physician or a member of the Society.

Sec. 12. The formation of salary schedules of all employees of the Society shall be the responsibility of the Board.

Sec. 13. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

CHAPTER VI
Commissions and Committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers of the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office.

Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec. 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

CHAPTER VII
Dues and Assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received.

Sec. 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of

Delegates and to any other benefits and privileges of membership.

CHAPTER VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

COMMENT: On July 18, 1981 the Board of Directors adopted the Principles of Medical Ethics of the AMA as the ethical guidelines of the Society.

CHAPTER IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

CHAPTER X
County Societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the secretary. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec. 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec. 5. The secretary of each county society shall keep a roster of its members.

CHAPTER XI
Specialty Sections

Section 1. The House of Delegates shall establish specialty sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

Sec. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors. Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec. 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec. 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec. 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec. 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

CHAPTER XII
Amendments

These Bylaws may be amended at any Annual Meeting by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day. ■

AMERICAN MEDICAL ASSOCIATION—PRINCIPLES OF MEDICAL ETHICS

PREAMBLE: The Medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Expense reimbursement policy and procedure for physicians on State Medical Society business

IT IS THE POLICY of the State Medical Society of Wisconsin to offer reimbursement of out-of-pocket expense incurred by its officers, directors, committee chairmen and members, AMA delegates and alternates and other designated physicians when such expense is incurred in the course of the conduct of business on behalf of the Society. The Society recognizes that any such leadership role requires a substantial contribution in personal time on the part of the physician. It is traditional that this be accepted as a contribution to the profession and the health of the public. However, out-of-pocket expenses in the discharge of official functions of the Society are reimbursable as set forth below, except that district directors are not reimbursed for the expense of attending the Annual Meeting of the Society (Bylaws, Chapter V, Sec. 4).

Officers, Directors, Committee Chairmen and Members, and Other Designated Persons

Reimbursable expenses include the cost of:

1. All meals, including normal tips, incurred while away from the physician's home city on SMS business.
2. All meals in the home city of the physician when these are in relation to an SMS business meeting.
3. Entertainment expenses where such expense is clearly a proper and necessary adjunct to the conduct of the physician's business function for the Society.
4. Valet and laundry services when the physician is away from the home city on SMS business continuously for four (4) days or more.
5. Lodging for those days (nights) reasonably associated with the dates of a meeting for which expenses are claimed.
6. Transportation from home city to meeting site and return as follows:

   Air—Cost of round trip coach airfare, plus necessary ground transportation.

   Bus/Train—Cost of round trip fare, plus necessary ground transportation.

   Auto—Mileage at the current Society rate (now 20¢) to and from the meeting site, plus necessary parking fees and highway tolls.

   Miscellaneous Ground Transportation—Local bus and cab fares as necessary.

   Auto Rental—All or some portion of such cost may be reimbursed as a substitute for other ground transport when this is the most feasible alternative following initial air, bus or train travel. Example, remote resort meeting site.
7. Telephone and telegraph communications relative to SMS business.

   Note: Use of least costly means of telephone communication is encouraged. Examples: In calling SMS Headquarters use toll-free number 1-800-362-9080 whenever possible. Similarly, use direct dial rather than credit card, whenever feasible.
8. Secretarial and copying services, postage and stationery used for SMS business.

   Note: SMS Headquarters is prepared to handle most official correspondence and reproduction work for officers and committee members. However, physicians may be reimbursed for personal or office costs relating to secretarial, copying, postage and stationery utilized in conducting SMS business.

   Note: Copies of all official correspondence should be sent to the appropriate committee staff person at SMS so as to assure proper coordination and recordkeeping.
9. Expenses, as described in 1-8 above, incurred by the physician's spouse when accompanying him/her in an official capacity or when the spouse is "expected" to be in attendance are reimbursable.

Procedure for Claiming Expenses

1. To obtain reimbursement the physician must submit a statement of expenses incurred.
2. Attach copies of bills or receipts for all lodging, travel, and meals over $25.
3. Itemize separately costs for Item 8 above.
4. Mail to SMS, Attn: Accounting Department, PO Box 1109, Madison, Wis 53701.

Reimbursement will be made within two weeks following receipt and approval of the expense report.

AMA Delegates and Alternates

AMA Delegates and Alternates from Wisconsin receive reimbursement as follows for each meeting of the AMA House of Delegates they attend:

Round Trip Coach Airfare, or up to equivalent in auto mileage at the current SMS mileage rate (now 20¢).

$600 cash to cover out-of-pocket expense.

When such delegates and alternates are conducting SMS business not in conjunction with meetings of the AMA House of Delegates, their expenses may be reimbursed in the same manner as outlined for Officers, Directors, etc.

Out-of-State Trips

With the exception of AMA House of Delegates meetings and travel by the President/President-Elect, all out-of-state trips must have prior approval by the Executive Committee to be reimbursable. Contact the Secretary and General Manager. ■

Approved by Board of Directors, July 18, 1981

THE HIPPOCRATIC OATH and the DECLARATION OF GENEVA are reproduced below for the convenience of physicians and others who may have need of them from time to time.

THE OATH OF HIPPOCRATES

I SWEAR BY APOLLO, THE PHYSICIAN, AND AESCULAPIUS AND HEALTH AND ALL-HEAL AND ALL THE GODS AND GODDESSES THAT, ACCORDING TO MY ABILITY AND JUDGMENT, I WILL KEEP THIS OATH AND STIPULATION:

TO RECKON him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I WILL FOLLOW that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary art of mischief and corruption; and further from the seduction of females or males, bond or free.

WHATEVER, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men at all times; but should I trespass and violate this oath, may the reverse be my lot.

DECLARATION OF GENEVA

Adopted by the General Assembly of the World Medical Association at Geneva, Switerland, September, 1948

AT THE TIME OF BEING ADMITTED AS MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due.

I WILL PRACTICE my profession with conscience and dignity.

THE HEALTH OF MY PATIENT will be my first consideration.

I WILL RESPECT the secrets which are confided in me.

I WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession.

MY COLLEAGUES will be my brothers.

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely, and upon my honor.

MEDICAL ETHICS

CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE American Medical Association, 1984. This new edition, originally compiled in 1958 and revised annually, is intended as an adjunct to the revised Principles of Medical Ethics that were adopted at the AMA Annual Convention in 1980. The opinions are intended as guides to responsible professional behavior, but they are not presented as the sole or only route to medical morality. Behavior relating to medical etiquette, custom or usage is not included.

The following topics are included in the booklet:

- **Opinions on Social Policy Issues**
  - Abortion
  - Abuse of Children, Elderly Persons, and Others at Risk
  - Allocation of Health Resources
  - Artificial Insemination
  - Artificial Insemination by Donor
  - Capital Punishment
  - Clinical Investigation
  - Costs
  - Fetal Research Guidelines
  - Genetic Counseling
  - Genetic Engineering
  - In Vitro Fertilization
  - Organ Transplantation Guidelines
  - Quality of Life
  - Terminal Illness
  - Unnecessary Services
  - Worthless Services
- **Opinions on Confidentiality, Advertising and Communications Media Relations**
  - Advertising and Publicity
  - Advertising and HMOs
  - Communications Media: Press Relations
  - Communications Media: Standards of Professional Responsibility
  - Confidentiality
  - Confidentiality: Attorney-Physician Relation
  - Confidentiality: Computers
  - Confidentiality: Insurance Company Representative
- **Opinions on Practice Matters**
  - Appointment Charges
  - Clinics
  - Consultation
  - Contingent Physician Fees
  - Contractual Relationship
  - Drugs and Devices: Prescribing
  - Informed Consent
  - Laboratory Services
  - Lien Laws
  - Neglect of Patient
  - Patient Information
  - Substitution of Surgeon Without Patient's Knowledge or Consent
- **Opinions on Hospital Relations**
  - Admission Fee
  - Assessments, Compulsory
  - Billing for Housestaff Services
  - Health Facility Ownership by Physician
  - Organized Medical Staff
  - Physician-Hospital Contractual Relations
  - Staff Privileges
- **Opinions on Physician Records**
  - Records of Physicians: Availability of Information to Other Physicians
  - Records of Physicians: Information and Patients
  - Records of Physicians on Retirement
  - Sale of a Medical Practice
- **Opinions on Professional Rights and Responsibilities**
  - Accreditation
  - Agreements Restricting the Practice of Medicine
  - Civil Rights and Professional Responsibility
  - Discipline and Medicine
  - Due Process
  - Free Choice
  - Patent for Surgical or Diagnostic Instrument
  - Peer Review
- **Opinions on Interprofessional Relations**
  - Nonscientific Practitioners
  - Nurses
  - Optometry
  - Referral of Patients
  - Specialists
  - Sports Medicine
  - Teaching
- **Opinions on Fees and Charges**
  - Fees for Medical Services
  - Fees: Group Practice
  - Fee Splitting
  - Fee Splitting: Clinic or Laboratory Referrals
  - Fee Splitting: Drug Prescription Rebates
  - Insurance Form Completion Charge
  - Interest Charges and Finance Charges
  - Laboratory Bill
  - Surgical Assistant's Fee
  - Competition

The State Medical Society of Wisconsin Board of Directors has adopted the AMA Principles of Medical Ethics as the ethical guidelines of the Society. The Society may refer to the Judicial Council Opinions for further guidance.

Copies of the *Opinions* are available by direct order to: Current Opinions (OP-122), American Medical Association, PO Box 10946, Chicago, IL 60610 (the distribution location of AMA publications).

The price is $6.00 each for 1-9 copies; $5.40 each for 10-49 copies; and $4.80 each for 50 copies or more. Prices include charges for handling and shipping. Residents of Illinois and New York, please add appropriate state sales tax to total.■

Life is short . . . Art is long . . . Experience is difficult

The Charitable, Educational and Scientific Foundation was established by the State Medical Society in 1955 to enable physicians and other friends of the profession to support, through gifts and grants, projects vitally affecting scientific medicine and public health. The Foundation's scope of interest has grown with increased volume of financial contributions to support a broad spectrum of programs affecting medical and health care needs in the State of Wisconsin.

Student Loans. The student loan program helps students finance their preparation for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Needy and deserving students may apply for and obtain loans carrying no interest until graduation. Since the program began nearly 860 students have received over one million dollars in long-term, low-interest loans. Of these, nearly 600 students have completed their repayments.

Continuing Medical Education. Postgraduate teaching programs are a major thrust of the Foundation. Among these are a Speakers Service to county medical societies, the Wilson Cunningham, MD Memorial Lecture for public health, the Elvehjem Memorial Lecture for scientific speakers at the Annual Meeting, the Barbara Scott Maroney Memorial Fund for papers and lectures on diabetes, and the William D Stovall MD Memorial Fund and the Beaumont Memorial Lecture for general education and scientific medicine. Since 1975 the Foundation has been the vehicle for implementation of the accreditation of CME programming of Wisconsin hospitals and specialty groups. To date, 57 hospitals, 25 specialty groups, and one county society have been accredited for Category I CME.

Research and Education. The Foundation plans, administers, and funds educational and research efforts of a scientific or medical-socioeconomic nature. One of these is the annual Wisconsin Workshop on Health aimed at health education of high school students and teachers, now in its 22nd year. The Foundation also supports the Wisconsin Science Congress, promotion of infant car seats, and the Postgraduate Workshop in the Basic Sciences. In addition, its E E Bryant, Jr Memorial Fund promotes educational activity involving law, engineering and medicine, and the C H and J G Crownhart Memorial Fund supports activities involving medical-legal issues.

Charitable Assistance. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

Medical History. The Foundation, through a subsidiary group known as the Aesculapian Society, owns and operates the restored Fort Crawford Military Hospital and Medical Museum at Prairie du Chien. It is one of the unique educational and cultural institutions in the midwest—a tribute to all Wisconsin physicians and their role in securing good health for the people of the state. This three-building medical museum complex pays special tribute to William Beaumont, MD, who during the 1830s conducted experiments on the digestive process. More than one-half million persons have visited the museum, which is a national historic landmark. Open from May through October, the museum depicts military and Indian medicine, important events in the history of medicine, replicas of physician and dental offices and pharmacies, and provides an array of health education exhibits including the transparent twins, health fads and fallacies, drug abuse, immunization, nutrition, emergency medicine, poisons in the home, safe driving, and the birth of a baby.

Opportunities for Giving. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor. In addition, service can be provided to those who wish to establish a Living Trust by naming the Foundation as trustee. Use of this mechanism can result in an immediate tax advantage for the donor while providing a guaranteed income for life. The principal would revert to the Foundation upon death of the donor.

All types of contributions to this Foundation are tax-deductible.

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Board of Directors and Officers of the State Medical Society of Wisconsin and up to 10 elected nonmedical persons. In addition each of the 55 component county societies may elect a representative who is considered a corporate member of the Board of Trustees. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board of Trustees. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

OFFICERS

PRESIDENT: R T Cooney MD, Portage—1985

VICE-PRESIDENT: S B Webster MD, La Crosse—1985

TREASURER: R W Edwards MD, Richland Center—1985

SECRETARY: Mr E R Thayer, Madison—1985

EXECUTIVE DIRECTOR: Kristin Bjurstrom, Madison

BOARD OF TRUSTEES

OFFICERS AND DIRECTORS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

J K Scott MD, Madison—1987
C W Landis MD, Milwaukee—1988
T T Flaherty MD, Neenah—1986
Mr E R Thayer, Madison—1986
J J Foley MD, Menomonee Falls—1986
D A Treffert MD, Fond du Lac—1988
D W Taebel MD, La Crosse—1987
V M Griffin MD, Mauston—1986
G H Franke MD, Milwaukee—1988
J W Fons Jr MD, Cudahy—1988
C S Eisenberg MD, Milwaukee—1986
L B Glicklich MD, Milwaukee—1987
T A Hofbauer MD, Menomonee Falls—1987
W H Konetzki MD, Waukesha—1987
Frederick Wood Jr MD, Kenosha—1987
W L Treacy MD, Milwaukee—1987
J D Kabler MD, Madison—1988
C M Hetsko MD, Madison—1988
J J Tydrich MD, Richland Center—1988
K I Gold MD, Beloit—1988
P M Jackson MD, La Crosse—1986
J J Kief MD, Rhinelander—1986
J K Park MD, Wisconsin Rapids—1988
R L von Heimburg MD, Green Bay—1986
J C DiRaimondo MD, Manitowoc—1988
J M Jauquet MD, Ashland—1987
W G Locher MD, Wausau—1986
M E Wegner MD, St Croix Falls—1986
K M Viste Jr MD, Oshkosh—1986
R D Fritz MD, Milwaukee—1987
W J Listwan MD, West Bend—1987
A E Schultz MD, Madison—1987
C W Freeby MD, Appleton—1987
P J Happe MD, Eau Claire—1988

NONMEDICAL TRUSTEES

Mrs Audrey Baird, Wauwatosa—1985
Mrs Nancy McDowell, Milwaukee—1985
Mrs Catherine McCormick, Shawano—1985
Mr George Kress, Green Bay—1987
Mr Robert B Murphy, Madison—1987
Mr Ronald W Lewis, Madison—1987
Mrs Mary Hoard, Fort Atkinson—1987
Mr James Bittner, Prairie du Chien—1987

CORPORATE MEMBERS REPRESENTING COMPONENT COUNTY MEDICAL SOCIETIES

Ashland-Bayfield-Iron: Vacancy—1986
Barron-Washburn-Burnett: D E Riemer MD—1985
Brown: Robert Schmidt Sr MD—1986
Calumet: J L Jaeck MD—1985
Chippewa: J J Sazama MD—1985
Clark: Vacancy—1987
Columbia-Marquette-Adams: R T Cooney MD—1986
Crawford: E M Dessloch MD—1986
Dane: R A Graf MD—1986
Dodge: Vacancy—1987
Door-Kewaunee: R G Evenson MD—1986
Douglas: C J Picard MD—1986
Eau Claire-Dunn-Pepin; G E Wahl MD—1985
Fond du Lac: Vacancy—1987
Forest: Vacancy—1987
Grant: C L Steidinger MD—1986
Green: Vacancy—1986
Green Lake-Waushara: Vacancy—1987
Iowa: H P Breier MD—1986
Jefferson: J S Garman MD—1987
Juneau: L J Radant—1987
Kenosha: H P Rafferty MD—1985
La Crosse: L J Logan MD—1987
Lafayette: L L Olson MD—1986
Langlade: E J Roth MD—1985
Lincoln: Vacancy—1987
Manitowoc: J R Larsen MD—1985
Marathon: Vacancy—1987
Marinette-Florence: C E Koepp MD—1986
Milwaukee: J D Levin MD—1986
Monroe: Vacancy—1987
Oconto: J S Honish MD—1986
Oneida-Vilas: J J Kief MD—1985
Outagamie: Vacancy—1986
Ozaukee: R F Henkle MD—1985
Pierce-St Croix: D M Woeste MD—1985
Polk: J O Simenstad MD—1985
Portage: Vacancy—1987
Price-Taylor: J R Keuer MD—1985
Racine: F J Scheible MD—1985
Richland: R W Edwards MD—1986
Rock: Vacancy—1986
Rusk: William Bauer MD—1985
Sauk: H P Baker MD—1986
Sawyer: Vacancy—1985
Shawano: J J Albright MD—1986
Sheboygan: J R Pawlak MD—1985
Trempealeau-Jackson-Buffalo: R N Yray MD—1987
Vernon: T J Devitt MD—1987
Walworth: Vacancy—1985
Washington: J E Albrecht MD—1985
Waukesha: Vacancy—1984
Waupaca: Vacancy—1987
Winnebago: G W Arndt MD—1986
Wood: L C Pomainville MD—1987■

CES Foundation

of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of April 1985.

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HARRINGTON-WRIGHT SCHOLARSHIP FUND

Ashland-Bayfield-Iron County Medical Auxiliary
Barron-Washburn-Burnett County Medical Auxiliary
Grant County Medical Auxiliary
Waukesha County Medical Auxiliary

WISCONSIN WORK WEEK ON HEALTH

State Medical Society of Wisconsin Auxiliary

IMPAIRED PHYSICIANS PROGRAM

Wisconsin Association for Medical Staff Service

BEAUMONT 500

Mrs Benjamin Brunkow and the late Dr Benjamin Brunkow
Dr Robert T Cooney

BROWN COUNTY STUDENT LOAN FUND

Mrs J C Adams
Mr and Mrs Michael Barnard
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Mr and Mrs Dudley Birder
Brown County Medical Auxiliary
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Mrs Raymond Burke
Mrs John Clancy
Miss Mary Clancy
Marie L Copps
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Mrs Dom Denessen
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Mr and Mrs Bruce Somers
Mr and Mrs Michael Stern
Betty Stathas
Mrs Thomas G Thyes
Mr and Mrs James L Van Egeren
Mr and Mrs Gerald P Warzella■

FACTS . . .
about the CES Foundation Student Loan Program

THE CHARITABLE, Educational and Scientific Foundation of the State Medical Society of Wisconsin is a nonprofit, nonstock Wisconsin corporation, which was chartered in June 1955. Its purpose is to "engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind.

Management: The Foundation's governing power is vested in a Board of Trustees composed of the Directors and Officers of the State Medical Society of Wisconsin and up to ten elected nonmedical persons. In addition, each of the 54 component county medical societies may elect a representative who is considered a corporate member of the Board. The Board meets at least annually. Routine affairs of the Foundation are directed by an Executive Committee consisting of the Officers of the State Medical Society, the Officers of the Foundation and certain elected Trustees.

Registration: The Foundation is registered with the Secretary of State as a charitable organization for purposes of contributions and fund-raising under Sec. 440.41 (2) Wis. Stats.

Tax Information: Contributions to the CES Foundation are deductible under both state and federal tax laws. The Foundation is a 501 (c) (3) corporation.

THE GENERAL STUDENT LOAN FUND

One of the most important activities of the CES Foundation is the Student Loan Program. Established in 1955, the Foundation's General Student Loan Fund is designed to assist needy, deserving students preparing for careers in medicine, dentistry, pharmacy, nursing, and other allied health fields. These long-term loans are interest free until after the student's graduation. Personnel in the financial aids departments of Wisconsin's schools cooperate with the Foundation in identifying needy and deserving students. Only students enrolled in Wisconsin schools are eligible for Foundation loans. The General Student Loan Fund is supported by general contributions earmarked for student loans.

SPECIAL STUDENT LOAN AND SCHOLARSHIP FUNDS

Although the Foundation's primary emphasis is on loans, some outright scholarships (grants) are made to fulfill the wishes of some donors. These special health career student loan and scholarship funds are administered by the Foundation according to the wishes of the individual or organization establishing and supporting the fund.

For example, a county medical society auxiliary may make an original endowment to the CES Foundation to establish a student loan or scholarship fund in the county auxiliary's name. The county auxiliary, as the benefactor, may decide what restrictions, if any, it wishes to place on the loans. Such restrictions may include:

- County residency requirements.
- Career specifications—medicine only or what other health careers to be included.
- Schools to which loans will be granted—you may wish to limit the fund to local university.
- Any limit or year of study—freshman only, upperclass only.
- Restrictions on amount of each loan.
- Amount of original endowment for the Fund.
- Additional requirements.

In establishing a special student loan or scholarship fund with the Charitable, Educational and Scientific Foundation, the following points should be considered:

- The CES Foundation will furnish an accounting annually to the benefactor or sponsoring organization.
- Brochures, folders, or other literature concerning the Fund may be distributed by any interested organization or person.
- Application blanks may be procured from the CES Foundation, 330 East Lakeside Street, PO Box 1109, Madison, Wis 53701, the benefactor, or college financial aids office.
- Applications will be accepted and considered without regard to race, color, creed, or national origin.
- The decision to approve individual loan applications, amount of the loan, and terms of repayment will be made only by the CES Foundation and will be based on the need demonstrated and availability of funds.
- The Foundation may, at its discretion (a) accept additional contributions to the Fund, (b) accept accelerated payments of obligations to the Fund, (c) waive repayment in hardship cases, and (d) increase or decrease rates of interest as the demands for loans may dictate.
- The Foundation may invest and reinvest assets of the Fund in accordance with prudent investment policies, and any interest or appreciation earned by such investments will accrue to the Fund.
- Direct expenses incurred by the Foundation in administering the Fund will be charged to the Fund. (At the present time, by action of the Board of Directors of the State Medical Society of Wisconsin, all expenses incurred by the student loan funds administered by the CES Foundation are paid by the Society.)
- In the event it is mutually determined that the purpose for which the Special Loan or Scholarship Fund was established no longer exists, the remainder of the Fund will be turned over to the Board of Trustees of the CES Foundation to use for other charitable, educational, and scientific purposes.

To inquire how you or your organization can establish a Special Student Loan or Scholarship Fund, contact Kristin Bjurstrom, Executive Director, CES Foundation, 330 East Lakeside Street, PO Box 1109, Madison, Wisconsin 53701; or phone 608/257-6781; toll-free in Wisconsin 1-800-362-9080. ■

"The Beaumont 500"

One of the most unique educational and cultural institutions in the midwest if not the nation, is the Fort Crawford Medical Museum. It is far more than a museum, it is a tribute to all Wisconsin physicians and their role in securing the good health of the people of the State of Wisconsin. It represents a unique concept in the public education for prevention and treatment of injury and disease, the nature of medical care, the importance of the strong physician-patient relationship, and emphasis on obtaining and keeping good health.

The restored Fort Crawford military hospital and its related museum in Prairie du Chien, is a tribute to Dr William Beaumont; it is also a modern expression of his 1830s philosophy of the search for truth and improvement in health. The museum has had more than 35,000 visitors since 1979, making it one of the most popular attractions in the area. Yet the museum continues to face financial hardships as well as some physical problems.

To this end, the MMP Endowment Fund was established in late 1981. This Fund has a goal of raising at least $500,000, the corpus of which cannot be used for any purpose other than to produce income earmarked for operation and maintenance of this unique National Historic Landmark.

The first 500 physicians or others who contribute $1,000 or more to the Museum Endowment Fund will join a select group known as the "Beaumont 500." Such contributors will receive a specially-designed Beaumont Medallion. In addition to being a member of the prestigious "Beaumont 500," those who contribute $10,000 or more will receive a first edition copy of Dr William Beaumont's famous book: *Experiments and Observations on the Gastric Juice and Physiology of Digestion*, written while Doctor Beaumont was stationed in Prairie du Chien, 1829-1832, and published in 1833.

To date, 19 individuals have contributed $1,000 each to the Museum Endowment Fund and several more have pledged support. Through the continued generosity of Wisconsin physicians and their spouses, the Fort Crawford Medical Museum can continue to familiarize our citizens—young and old—with the fascinating people and events that have helped shape Wisconsin medicine.

MEDICAL MUSEUM ENDOWMENT FUND

Name_____

Address_____

City/State/Zip _____

☐ Yes, I (we) would like to be a member of The Beaumont 500. Enclosed is my (our) contribution of $1,000 or more.

☐ Yes, I (we) would like to be a member of The Beaumont 500 and receive a first edition copy of Dr. Beaumont's book. Enclosed is my (our) contribution of $10,000 or more.

☐ Yes, I (we) would like to support medical history by contributing to the Medical Museum Endowment Fund.

The ultimate in appreciation of medical history

"The Beaumont 500"

Donations of $1,000 or more made payable to:

Charitable, Educational and Scientific Foundation
PO Box 1109
Madison, Wisconsin 53701

608/257-6781

BOARD DISTRICTS AND DIRECTORS: 1985–1986

District — Director

1—Glenn H Franke, MD, Milwaukee
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Philip J Happe, MD, Eau Claire

8—Joseph M Jauquet, MD, Ashland

SMS Placement Service aids physicians and communities

ONE OF THE MANY FUNCTIONS of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to physicians who contact Placement Service indicating a desire to locate in Wisconsin or to relocate within the state. A list of physicians is sent to communities requesting assistance in obtaining a physician. The physicians and communities may then contact one another. Physicians seeking associates also may request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results occur but more time usually means better results.

It should be noted that Placement Service is not a recruiting effort. Its function is supported by membership in the State Medical Society of Wisconsin. The Society does, however, cooperate with the state-supported Office of Rural Health in its New Physicians for Wisconsin Program which provides placement services to communities and physicians on a fee basis determined by budgetary funds available.

Physicians and communities also may utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal.* This classified advertising section is available to members of the State Medical Society, other physicians, communities, clinics, hospitals, recruitment firms, and others at reasonable rates.

Physicians using the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; tel 608/257-6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis 53701. ■

OFFICERS AND DIRECTORS: 1985–1986

Officers of the Society

President (1985-1986)
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Charles W Landis, MD, 2350 North Lake Dr, Milwaukee 53211

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Carl S Eisenberg, MD (1983-1986): PO Box 17300, Milwaukee 53217
Thomas A Hofbauer, MD (1984-1987): PO Box 427, Menomonee Falls 53051
Wayne H Konetzki, MD (1984-1987): 403 N Grand Ave, Waukesha 53186
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Richard D Fritz, MD (1984-1987): 788 N Jefferson St, Milwaukee 53202
William J Listwan, MD (1984-1987): 279 S 17th Ave, West Bend 53095
Fredrick Wood Jr, MD (1984-1987): 6530 Sheridan Rd, Kenosha 53140
William L Treacy, MD (1984-1987): 10125 W North Ave, Milwaukee 53226

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J D Kabler, MD (1985-1988): 1522 University Ave, Madison 53706
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Alwin E Schultz, MD (1984-1987): 222 N Midvale Blvd, Madison 53705
Kenneth I Gold, MD (1985-1988): 1905 Huebbe Parkway, Beloit 53511

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Jung K Park, MD (1985-1988): 410 Dewey St, Wisconsin Rapids 54494
W George Locher, MD (1983-1986): 3326 N 11th St, Wausau 54401

Fifth: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

Darold A Treffert, MD (1985-1988): 459 E First St, Fond du Lac 54935
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C William Freeby, MD (1984-1987): 1818 N Meade St, Appleton 54911

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* * *

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DeLore Williams, MD (1985-1986), 8501 W Lincoln Ave, West Allis 53227
Patricia J Stuff, MD (1985-1986), PO Box 366, Bonduel 54107
John K Scott, MD (1985-1986), 20 South Park St, #350, Madison 53715
Henry F Twelmeyer, MD (1985 / 1986-1987), 2500 N Mayfair Rd, Wauwatosa 53226
Richard W Edwards, MD (1985 / 1986-1987), 1313 W Seminary St, Richland Center 53581
Cornelius A Natoli, MD (1985 / 1986-1987): 2760 Hagen Rd, La Crosse 54601

Alternate Delegates to the AMA

Charles W Landis, MD (1985), 2350 North Lake Dr, Milwaukee 53211
John D Riesch, MD (1985-1986), PO Box 427, Menomonee Falls 53051
Cyril M Hetsko, MD (1985-1986), 1313 Fish Hatchery Rd, Madison 53715
John P Mullooly, MD (1985-1986): 8430 W Capitol Dr, Milwaukee 53222
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Kenneth M Viste Jr, MD (1985 / 1986-1987), 100 Stoney Beach Rd, Oshkosh 54901
Richard H Ulmer, MD (1985 / 1986-1987), 1000 N Oak Ave, Marshfield 54449■

*Map indicating location of districts appears on opposite page.

NOTE: Officers, directors, delegates, alternate delegates, and members of commissions and committees are elected at the Annual Meeting (April 1985). Dates in parentheses indicate beginning and expiration of term of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the Annual Meeting.

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Speaker of the House of Delegates
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Chairman, Finance Committee
John J Kief, MD, Rhinelander
Member-at-large
EX OFFICIO nonvoting members
President and President-elect of SMS Auxiliary

Finance Committee of the Board

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Philip J Happe, MD, Eau Claire, 1988
Jerome W Fons Jr, MD, Cudahy, 1987
Richard D Fritz, MD, Milwaukee, 1987
Joseph M Jauquet, MD, Ashland, 1987
James J Tydrich, MD, Richland Center, 1986
John J Foley, MD, Menomonee Falls
Treasurer, ex officio ■

SMS Services, Inc: 1985

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John P Mullooly MD, Milwaukee, 1987, *Vice President*
Richard W Edwards MD, Richland Center, 1985,
Treasurer
Earl R Thayer, Madison, 1987, *Secretary*
Timothy T Flaherty MD, Neenah, 1985
William A Nielsen MD, West Bend, 1985
Jerome W Fons Jr MD, Cudahy, 1986
Allen O Tuftee MD, Beloit, 1986
John J Foley MD, Menomonee Falls, 1987

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LeRoy A Johnson, Madison, *Executive Vice President* ■

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ELECTED OFFICERS

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President-elect: Mrs Charles Dungar, 410 West Prospect Avenue, Appleton 54911
Vice President: Mrs James Kuplic, 161 Valley Road, Sheboygan Falls 53085
Secretary: Mrs Charles Hammond, 536 Reford Road, Neenah 54956
Treasurer: Mrs W E Rosenkranz, W254 S3896 Oakdale Drive, Waukesha 53186
Immediate Past President: Mrs Robert Baldwin, 119 Concord Avenue, Watertown 53094

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Bluff: Mrs Patrick Connerly, 4675 Allemande Court, Eau Claire 54701
Capital: Mrs William Funcke, Route 1, Heritage Hill Road, Beaver Dam 53916
Fox Valley: Mrs David Lawrence, PO Box 1514, Fond du Lac 54935
River: Mrs Stephen Webster, 2250 Wedgewood Drive, East, La Crosse 54601
Gateway: Mrs Richard Clasen, 711 Ver Bunker Avenue, Port Edwards 54469
Kettle Moraine: Mrs William Davies, 205 Windsor Drive, Waukesha 53186
Lakeshore: Mrs Donald Gore, 2528 North Third Street, Sheboygan 53081
North Woods: Mrs Charles Longstreth, Route 1, Box 163J, Maple Ridge Road, Ashland 54806
Rib Mountain: Mrs Thomas Starkey, 1803 Stark Street, Wausau 54401

APPOINTED OFFICERS

Historian: Mrs Herbert Sandmire, 201 St Mary's Boulevard, Green Bay 54301
Parliamentarian: Mrs Robert E Johnston, 3825 Waubenoor Drive, Green Bay 54301

EXECUTIVE SECRETARY

Mrs La Verne Bartel, 330 East Lakeside Street, Madison 53715 ■

Charitable, Educational and Scientific Foundation: 1985–1986

(See listing elsewhere in this issue) ■

PAST PRESIDENTS OF THE STATE MEDICAL SOCIETY OF WISCONSIN: 1961–1985

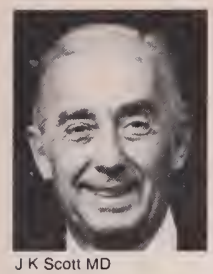
This is a partial listing. The complete listing from 1841 to 1972 appeared in the January 1973 issue.

Leif H Lokvam, MD, Kenosha 1961-1962
Nels A Hill, MD, Madison 1962-1963
†William J Egan, MD, Milwaukee 1963-1964
William P Curran, MD, Antigo 1964-1965
†John H Houghton, MD, Wisconsin Dells 1965-1966
†Frank E Drew, MD, Milwaukee 1966-1967
Harold J Kief, MD, Fond du Lac 1967-1968
†William D James, MD, Oconomowoc 1968-1969
Robert E Callan, MD, Milwaukee 1969-1970
†Jerry W McRoberts, MD, Sheboygan 1970-1971
George A Behnke, MD, Kaukauna 1971-1972
Robert F Purtell, MD, Milwaukee 1972-1973
Gerald J Derus, MD, Madison 1973-1974
John E Dettmann, MD, Green Bay 1974-1975
Howard L Correll, MD, Arena 1975-1976
Charles J Picard, MD, Superior 1976-1977
Roy B Larsen, MD, Wausau 1977-1978
Jules D Levin, MD, Milwaukee 1978-1979
Darold A Treffert, MD, Fond du Lac 1979-1980
Russell F Lewis, MD, Marshfield 1980-1981
Albert J Motzel Jr, MD, Waukesha 1981-1982
Gerald C Kempthorne, MD, Spring Green 1982-1983
Chesley P Erwin, MD, Milwaukee 1983-1984
Timothy T Flaherty, MD, Neenah ..... 1984-1985 ■

†Deceased

OFFICERS AND DIRECTORS: 1985–1986

State Medical Society of Wisconsin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C W Landis MD
President-elect

T T Flaherty MD
Past President

D A Treffert MD
Board Chairman,
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E R Thayer
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J J Foley MD
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Director, Dist 1

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G H Franke MD
Director, Dist 1

R D Fritz MD
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J D Kabler MD
Director, Dist 2

J J Tydrich MD
Director, Dist 2

A E Schultz MD
Director, Dist 2

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J K Park MD
Director, Dist 4

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Director, Dist 4

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J C DiRaimondo MD
Director, Dist 6

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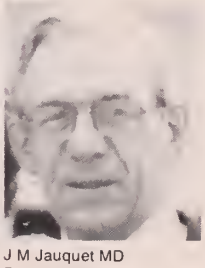
M E Wegner MD
Director, Dist 7


J M Jauquet MD
Director, Dist 8

COMMISSIONS AND COMMITTEES: 1985–1986

STATE MEDICAL SOCIETY OF WISCONSIN
330 East Lakeside St (PO Box 1109), Madison, Wisconsin 53701
Telephone: 608/257-6781 (toll-free in Wisconsin 1-800-362-9080)

COMMISSIONS

Continuing Medical Education

This commission shall consist of up to 20 appointed members and the deans of the two medical schools in Wisconsin, or their designees, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commissions on Peer Review and Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the Annual Meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

Frank E Berridge, MD, Milwaukee, 1986
Martin Z Fruchtman, MD, Waukesha, 1986
J David Lewis, MD, West Bend, 1986
Joseph J Mazza, MD, Marshfield, 1986
Kathy P Belgea, MD, Wausau, 1986
James T Houlihan, MD, Woodruff, 1987
Charles L Junkerman, MD, Milwaukee, 1987
Charles E Holmburg, MD, Waukesha, 1987
Benson L Richardson, MD, Green Bay, 1987
Kay A Heggestad, MD, Madison, 1987
C William Freeby, MD, Appleton, 1988, Chairman
Bradley G Garber, MD, Osseo, 1988
Kenneth I Gold, MD, Beloit, 1988
Edwin L Overholt, MD, La Crosse, 1988, V-Chrmn
Thomas P Simerson, MD, Merrill, 1988
Bernard B Poeschel, MD, Eau Claire, 1988

Medical School Deans' designees:
Thomas C Meyer, MD, UW-Madison
Willard Duff, PhD, Medical College of Wisconsin

CME COMMITTEE

Subcommittee on Accreditation

Bradley G Garber, MD, Osseo, Chairman
William Card, MD, Madison
John A Palese, MD, Milwaukee
Melvin F Huth, MD, Baraboo
Warren J Holtey, MD, Marshfield
Joseph J Mazza, MD, Marshfield
Jerold J Beerends, MD, West Bend
Eugene Musser, MD, Madison
Edward Znpanc, MD, Monroe
Arnold Effron, MD, Oconomowoc
Philip H Utz, MD, La Crosse
Richard D Lindgren, MD, Madison
Fevzi Pamukcu, MD, Kenosha
Edward F Banaszak, MD, Milwaukee

Expiration of term at Annual Meeting of the year designated appears following member's name. Chairmen and vice chairmen of commissions and committees are elected at the first meeting following the Annual Meeting; therefore, most of the chairmen and vice chairmen listed here are subject to change. The BLUE BOOK is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

Health Planning

This commission shall be concerned about planning for health care, including facilities and services and their organization to assure availability, access and quality of care; standards, guidelines and regulations affecting health care; distribution of medical services; relationships with allied health personnel; and matters pertaining to the Joint Commission on Accreditation of Hospitals.

This commission also includes representatives of specialty sections / societies with voting rights when present, provided they are SMS members, such appointments subject to approval by the Board of Directors.

Clarence R Hart, MD, Lake Geneva, 1986
Fredric L Hildebrand, MD, Neenah, 1986, Chairman
Marvin G Parker, MD, Racine, 1986
Sigurd E Siverston, MD, Madison, 1986
Vernette M Carlson, MD, Waukesha, 1986
James G Caya, MD, Burlington, 1986
Peter L Eichman, MD, Madison, 1987
Jan E Erlandson, MD, Monroe, 1987
D Joseph Freeman, MD, Wausau, 1987
Guenther P Pohlmann, MD, Milwaukee, 1987
Lee M Tyne, MD, Brookfield, 1987
Ann Bardeen, MD, Oconomowoc, 1987
Joseph B Durst, MD, La Crosse, 1988
Bradley J Sullivan, MD, Marshfield, 1988
Philip J Dougherty, MD, Menomonee Falls, 1988
Thomas F Garland, MD, Milwaukee, 1988
Kermit L Newcomer, MD, La Crosse, 1988, V-Chrmn
Michael E Tieman, MD, Berlin, 1988

SPECIALTY REPRESENTATIVES

Society

Allergy: *J Brent Kooistra, MD,* Madison
Internal Medicine: *Kenneth R Kubsch, MD,* Green Bay
Neurological: *Gamber F Tegtmeyer, MD,* Madison
Obstetrics and Gynecology: *Norman J Schroeder, MD,* Beaver Dam
Pathology: *Edward A Burg Jr, MD,* Milwaukee
Pediatrics (Wisconsin Chapter): *Gary R Gutcher, MD,* Madison
Physical Medicine and Rehabilitation: *Albert M Cohen, MD,* Milwaukee
Radiological: *Robert E Durnin, MD,* Madison
Surgeons (Wisconsin Chapter): *John T Mendenhall, MD,* Madison
Surgical: *P Richard Sholl, MD,* Janesville
Clinic Managers: *Joseph Jepsen,* Eau Claire

SMS Section

Dermatology: *Hal Ridgway, MD,* Madison
Emergency Medicine: *Thomas A Reminga, MD,* Milwaukee
Ophthalmology: *James C Allen, MD,* Madison
Otolaryngology: *Timothy J Donovan, MD,* Madison
Pathology: *Charles P Nichols, MD,* La Crosse
Physical Medicine and Rehabilitation: *John L Melvin, MD,* Milwaukee

Mediation and Peer Review

This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, professional ethics, and fees. When necessary, it shall

COMMITTEES

Aging, Extended Care Facilities, and Home Health Care

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care and home care.

Frederick W Blancke, MD, Madison, 1986
Ricardo M Rustia, MD, Kenosha, 1986
Nunilo L Bugarin, MD, Tomahawk, 1986
Kay E Jewell, MD, Madison, 1986
Sailendra N Basu, MD, Wausau, 1986
Robert E Phillips, MD, Marshfield, 1987
Terrence N Hart, MD, Brookfield, 1987
Richard J Hendricks, MD, Madison, 1987
Wilbur E Rosenkranz, MD, Mukwonago, 1987, V-Chrmn
Edward R Winga, MD, La Crosse, 1987
Roland R Liebenow, MD, Lake Mills, 1988, Chairman
Elston L Belknap Jr, MD, Madison, 1988
Edward L Perry, MD, La Crosse, 1988
William T Russell, MD, Sun Prairie, 1988
Curt Hancock, MD, Sheboygan, 1988
Paul E Hankwitz, MD, Milwaukee, 1988
Mrs William (Joan) Janssen, Mequon, Auxiliary

Alcoholism and Other Drug Abuse

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Pauline M Jackson, MD, La Crosse, 1986
Charles W Landis, MD, Milwaukee, 1986
David R Downs, MD, Dodgeville, 1986
Glenn H Franke, MD, Milwaukee, 1986
Herbert White, DO, Genesee Depot, 1987
Nunilo L Bugarin, MD, Tomahawk, 1987
Fred H Koenecke, MD, Madison, 1987
Warren H Williamson, MD, Racine, 1987
Daniel S Thearle, MD, Neenah, 1987
Roland E Herrington, MD, Milwaukee, 1988, Chairman
David L Nelson, MD, Stoughton, 1988
Charles Goodell, MD, Tomahawk, 1988
John T Andersen, MD, Milwaukee, 1988
David Benzer, DO, Wauwatosa, 1988
Edward J Johnson, MD, Green Bay, 1988
Mrs K Alan (Sherry) Stormo, Fond du Lac, Auxiliary

Environmental and Occupational Health

This committee shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

Melvin S Blumenthal, MD, Monroe, 1986
Robert W Page, MD, Marshfield, 1986
Wendelin W Schaefer, MD, Sheboygan, 1986
Carl Zenz, MD, West Allis, 1986
Ruth R Schuh, MD, Watertown, 1986
Jacob Martens, MD, Wausau, 1986
John S Moore, MD, Milwaukee, 1987
Henry A Anderson III, MD, Madison, 1987
John J Beck, MD, Sturgeon Bay, 1987
Erwin S Huston, MD, Milwaukee, 1987
John T Schmitz, MD, Milwaukee, 1987
Raymond Johnson, MD, Milwaukee, 1987
Lawrence Smith, MD, Racine, 1987
Mrs W W (Jame) Schaefer, Sheboygan, Auxiliary

Health Care Costs Liaison

This committee shall be concerned with promoting an ongoing dialogue with business, industry, and labor. As part of this dialogue special emphasis will be placed on issues relating to the rapidly escalating costs of health care.

James V Seegers, MD, Elkhorn, 1986
Stephen Hathway, MD, Green Bay, 1986
Jeremy R Green, MD, Green Bay, 1986
Warren H Williamson, MD, Racine, 1986
Russell F Lewis, MD, Marshfield, 1987, Chairman
Gerald C Kempthorne, MD, Spring Green, 1987
William C Miller, MD, Wausau, 1987
Rosanna M Ranieri, MD, Kenosha, 1987
Albert J Motzel Jr, MD, Waukesha, 1988, V-Chrmn
Raymond R Johnson, MD, Milwaukee, 1988
Ann C Beecher, MD, Mequon, 1988
Richard H Christenson, MD, Milwaukee, 1988
Carleton B Davis Jr, MD, Monroe, 1988

Joint Practice SMS/Wisconsin Nurses Association

This committee shall be concerned with developing recommendations, as appropriate, regarding education, legislation, practice arrangements and delivery patterns; shall facilitate understanding and acceptance by the professions and the public of changing medical and nursing relationships, roles and practices; shall serve as a consultation resource in matters that relate to joint practice.

James J Tydrich, MD, Richland Center, Cochairman
Ilse Hecht, RN, Madison, Cochairman
Robert T Cooney, MD, Portage
Marc F Hansen, MD, Madison
Judy Ellington, RN, Baraboo
Leona Vandevusse, RN, Milwaukee

Maternal and Child Health

This committee shall be concerned about all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Gary R Gutcher, MD, Madison, 1986
John E Inman, MD, Monroe, 1986
Joanne Selkurt, MD, Whitehall, 1986
Ferrin C Holmes, MD, Sturgeon Bay, 1986
Laura Mueller, MD, Racine, 1986
Gloria M Halverson, MD, Waukesha, 1987
Daniel F Johnson, MD, Eau Claire, 1987
Sharon L Maby, MD, Marshfield, 1987
Walter R Schwartz, MD, Wauwatosa, 1987, Chairman
Robert J Jaeger, MD, Stevens Point, 1987
Michael H Mader, MD, La Crosse, 1988, Chairman
Charles Hammond, MD, Neenah, 1988
Perry A Henderson, MD, Madison, 1988
John D Swanson, MD, Neenah, 1988
Mrs. Robert (Roberta) Baldwin, Watertown, Auxiliary
Mary-Frances Woods, MCW, Milwaukee (medical student)

SUBCOMMITTEE

Study Committee on Maternal Mortality Survey

Gloria M Halverson, MD, Waukesha, Chairman
Richard C Brown, MD, Eau Claire
Perry A Henderson, MD, Madison
Frederick J Hofmeister, MD, Wauwatosa
Stanley A Korducki, MD, Milwaukee

continued next page

initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, fees, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Robert E Johnston, MD, Green Bay, 1986, Chairman
D Mark Lochner, MD, Waupaca, 1986
Harry F Weisberg, MD, Milwaukee, 1986
David E Westgard, MD, La Crosse, 1986
Michael E Nesemann, MD, La Crosse, 1986
Robert T Cooney, MD, Portage, 1986
Melvin F Huth, MD, Baraboo, 1986
Lyle L Olson, MD, Darlington, 1986
Sharon L Elias, MD, Milwaukee, 1987
Joseph B Grace, MD, Green Bay, 1987
James M Huffer, MD, Madison, 1987
Thomas F Jennings, MD, West Allis, 1987
John B McAndrew, MD, Oshkosh, 1987
Robert E Phillips, MD, Marshfield, 1987
William E Raduege, MD, Woodruff, 1987
Richard C Zimmerman, MD, Waukesha, 1987
G Robert Kaftan, MD, Green Bay, 1987
Albert H Adams, MD, Milwaukee, 1988
Domenick S Bruno, MD, Milwaukee, 1988
Ronald J Darling, MD, Waukesha, 1988
John A DeGiovanni, MD, Prairie du Sac, 1988
Richard W Edwards, MD, Richland Center, 1988
Charles S Geiger Jr, MD, West Bend, 1988, V-Chrmn
Michael R McCormick, MD, Waukesha, 1988

MPR COMMITTEES

Coordinating Council on Physician Impairment

Gerald C Kempthorne, MD, Spring Green
Roland E Herrington, MD, Milwaukee
Arthur G Norris, MD, Milwaukee
(State Medical Society)
Ms Gwen Jackson, Milwaukee
George W Arndt, MD, Neenah
Patricia R Raftery, DO, Sparta
(Medical Examining Board)

Managing Committee, Statewide Impaired Physician Program

Roland E Herrington, MD, Milwaukee
Gerald C Kempthorne, MD, Spring Green
Fred H Koenecke Jr, MD, Madison
Arthur G Norris, MD, Milwaukee
A Bela Maroti, Milwaukee
John C LaBissoniere, Madison

Medicaid Medical Audit Committee

John A DeGiovanni, MD, Prairie du Sac
Richard W Edwards, MD, Richland Center
Charles S Geiger Jr, MD, West Bend
Leo R Grinney, MD, Racine
John P Hartwick, MD, Milwaukee
Gerald C Kempthorne, MD, Spring Green
John J Kief, MD, Rhinelander
D Mark Lochner, MD, Waupaca
Virgil L Sharp, DO, Waterloo
G John Weir Jr, MD, Marshfield
David E Westgard, MD, LaCrosse
Alfred D Dally, MD, Madison

Physicians Alliance Commission

The Board of Directors is in the process of completing appointments to a reorganized Physicians Alliance Commission, combining with it the former Governmental Affairs Commission.

It also is appointing a Task Force on Medical Liability and a Task Force on Physician Review and Discipline.

The memberships and charges to these groups will appear in the July issue.

Public Information

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations, and recruit and retain physician members of the Society and encourage their active participation in the affairs of the county and state societies and the American Medical Association.

Irwin J Bruhn, MD, Walworth, 1986, Chairman
George L Gay Jr, MD, Cambridge, 1986
Alan H Cherkasky, MD, Kaukauna, 1986, V-Chrmn
Carl R Poley, MD, Green Bay, 1987
Arthur G Barbier, MD, LaCrosse, 1987
Paul D Nelsen, MD, Ripon, 1987
William H Annesley Jr, MD, Milwaukee, 1988
Cindy L Barron, MD, Madison, 1988
Vinoo Cameron, MD, Medford, 1988
Jefferson F Ray III, MD, Marshfield, 1988
Mrs David (Jean) Lawrence, Fond du Lac, Auxiliary

Wisconsin Medical Journal

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

EDITORIAL BOARD

Victor S Falk, MD, Edgerton, 1986
Chairman and Medical Editor
Dean M Connors, MD, Madison, 1986
Melvin F Hutli, MD, Baraboo, 1986
Darrell L Witt, MD, Wausau, 1986
Charles H Raine, MD, Racine, 1987
M C F Lindert, MD, Milwaukee, 1987
Richard D Sautter, MD, Marshfield, 1987
George W Kindschi, MD, Monroe, 1988
Andrew B Crummy Jr, MD, Madison, 1988
Garrett A Cooper, MD, Madison, *Emeritus*

EDITORIAL ASSOCIATES
(appointed annually by Board of Directors)

Wayne J Boulanger, MD, Milwaukee
Chairman and *Editorial Director*
Victor S Falk, MD, Edgerton, *Medical Editor*
Russell F Lewis, MD, Marshfield
R Buckland Thomas, MD, Monroe
Raymond A McCormick, MD, Green Bay

* * *

MATERNAL MORTALITY SURVEY *continued*

Thomas A Leonard, MD (Emeritus), Middleton
Ronald W Olson, MD, Madison
Robert P Reik, MD, Wauwatosa
Herbert F Sandmire, MD, Green Bay
Albert H Stahmer, MD, Wausau
Everett A Beguin, MD, La Crosse
John E Inman, MD, Monroe
Dan F Johnson, MD, Eau Claire
Richard F Mattingly, MD, Milwaukee
William E Martens, MD, Wauwatosa
Bernard Poeschel, MD, Eau Claire
E Howard Theis, MD, Fond du Lac

Medicine and Religion

This committee shall be concerned about the medical-spiritual values of health care and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

John W Faber, MD, Neenah, 1986
E Basil Jackson, MD, Milwaukee, 1986
G Daniel Miller, MD, Oconomowoc, 1986
John K Scott, MD, Madison, 1986
Maxwell H S Weingarten, MD, Milwaukee, 1986
Carl R Poley, MD, Green Bay, 1986
Frank J Cerny, MD, Fond du Lac, 1987
William O Myers, MD, Marshfield, 1987
Milo G Durst, MD, Milwaukee, 1987
John C Jordan, MD, Richland Center, 1987
Gilbert J Nock Jr, MD, Milwaukee, 1987
John O Simenstad, MD, Osceola, 1988, Chairman
John P Mullooly, MD, Milwaukee, 1988, V-Chrmn
James V Seegers, MD, Elkhorn, 1988
John B Weeth, MD, La Crosse, 1988
Maureen Murphy, SSM, MD, Wisconsin Dells, 1988
Mrs Glenn (Lila) Seager, La Crosse, Auxiliary

Physician-Nurse Liaison

This committee shall review shared concerns as they relate to training, vocation, licensure, organization, structure, practice, decision-making on hospital staffs, technology advances, recruitment and retention, autonomy, patient care.

Albert J Motzel Jr, MD, Waukesha, *Cochairman*
Rosellen Crow, RN, Middleton, *Cochairman*
Carl S Eisenberg, MD, Milwaukee
Michael P Mehr, MD, Marshfield
Philip H Utz, MD, La Crosse
Norma Lang, RN, Milwaukee
Sherry Quamme, RN, Columbus

Mental Health

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total well-being.

Gary M Herdrich, MD, West Bend, 1986
Margaret J Seay, MD, Oshkosh, 1986
Barry Blackwell, MD, Milwaukee, 1986
Peter L Eichman, MD, Madison, 1986
Rudolf W Link, MD, Madison, 1986
Frederick Fosdal, MD, Madison, 1987
Robert B Shapiro, MD, Madison, 1987
Charles W Landis, MD, Milwaukee, 1987, V-Chrmn
Clarence E Moore, MD, Fond du Lac, 1987
Mary K Kubiak, MD, Omro, 1987
Pauline M Jackson, MD, La Crosse, 1988, Chairman
William W Garitano, MD, Marshfield, 1988
Donald L Feinsilver, MD, Milwaukee, 1988
Bruce C Rhoades, MD, Wausau, 1988
Wess R Vogt, MD, Milwaukee, 1988
Mrs C A (Marla) Natoli, La Crosse, Auxiliary

Safe Transportation

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

James M Huffer, MD, Madison, 1986
Clarence E Moore, MD, Fond du Lac, 1986
John C Heffelfinger, MD, Watertown, 1986
Glenn C Hillery, MD, Lancaster, 1987
Kathryn P Nichol, MD, Madison, 1987
James L Weygandt, MD, Kohler, 1987, Chairman
Ralph F Hudson, MD, Eau Claire, 1988
Walter F Smejkal, MD, Manitowoc, 1988
Stephen W Hargarten, MD, Milwaukee, 1988
Susan Kinast-Porter, MD, Monroe, 1988
Mrs Donald (Audrey) Peterson, Madison, 1988

School Health

This committee shall be concerned about protecting and improving the health of those attending the public or private schools of this state, including matters related to athletics.

Lawrence K Siegel, MD, Waukesha, 1986, V-Chrmn
Roy E Buck, MD, Oshkosh, 1986
George H Handy, MD, Madison, 1987
Rolf L Simonson, MD, Sheboygan, 1987
Horace K Tenney III, MD, Madison, 1987
James C H Russell, MD, Ft Atkinson, 1988, Chairman
Conrad L Andringa, MD, Madison, 1988
James S Janowiak, MD, Merrill, 1988
Mrs Kenneth (Mary) Smigielski, Milwaukee, Auxiliary
Mrs K Alan (Sherry) Stormo, Fond du Lac, Auxiliary

Women Physicians

This committee shall serve as liaison and women's advocate with other commissions and committees of the State Medical Society. It shall encourage state, county, and specialty societies to make special efforts to recruit women physicians to membership in organized medicine, subsequently to consider them for leadership positions based on their professional capabilities rather than as women physicians. It shall promote medical education that is sensitive and responsive to women's healthcare needs and enhance educational opportunities for women. It also shall serve as a resource to the State Medical Society, other groups, and individuals on women's health issues. It shall consist of nine members appointed by the Board of Directors.

Carl S Eisenberg, MD, Milwaukee, 1986
Pauline M Jackson, MD, La Crosse, 1986
Janet C Lindemann, MD, Waukesha, 1986
Sandra L Osborn, MD, Madison, 1986
Hansi R Patience, MD, Sturgeon Bay, 1987
Anne M Riendl, MD, Waukesha, 1987
Jean H Schott, MD, Milwaukee, 1987
Patricia J Stuff, MD, Bonduel, 1988, Chairman
Carol Young, MD, Milwaukee, 1988
Kay E Jewell, MD, Madison, 1988
Gilbert J Nock Jr, MD, Milwaukee, 1988
Mrs Donald A (Audrey) Peterson, Madison, Auxiliary■

HOUSE OF DELEGATES: See page 44 of March issue.

NOMINATING COMMITTEE: 1985, House of Delegates: See page 163 of this issue.

DISTRICT 1
Lois Riley
(414/271-4328)

County medical societies

Milwaukee
Waukesha
Ozaukee
Washington
Sheboygan
Kenosha
Racine
Walworth

DISTRICT 2
Lanny Hardy
(608/257-6781)

County medical societies

Columbia-Marquette
Adams
Green Lake-
Waushara
Lafayette
Richland
Jefferson
Green
Iowa
Grant
Rock

DISTRICT 3
Deborah Bowen Wilke
(414/964-5046)

County medical societies

Oneida-Vilas
Lincoln
Marinette-Florence
Forest
Langlade
Shawano
Outagamie
Brown
Door-Kewaunee
Calumet
Oconto
Marathon
Wood
Portage
Waupaca
Winnebago
Fond du Lac
Manitowoc

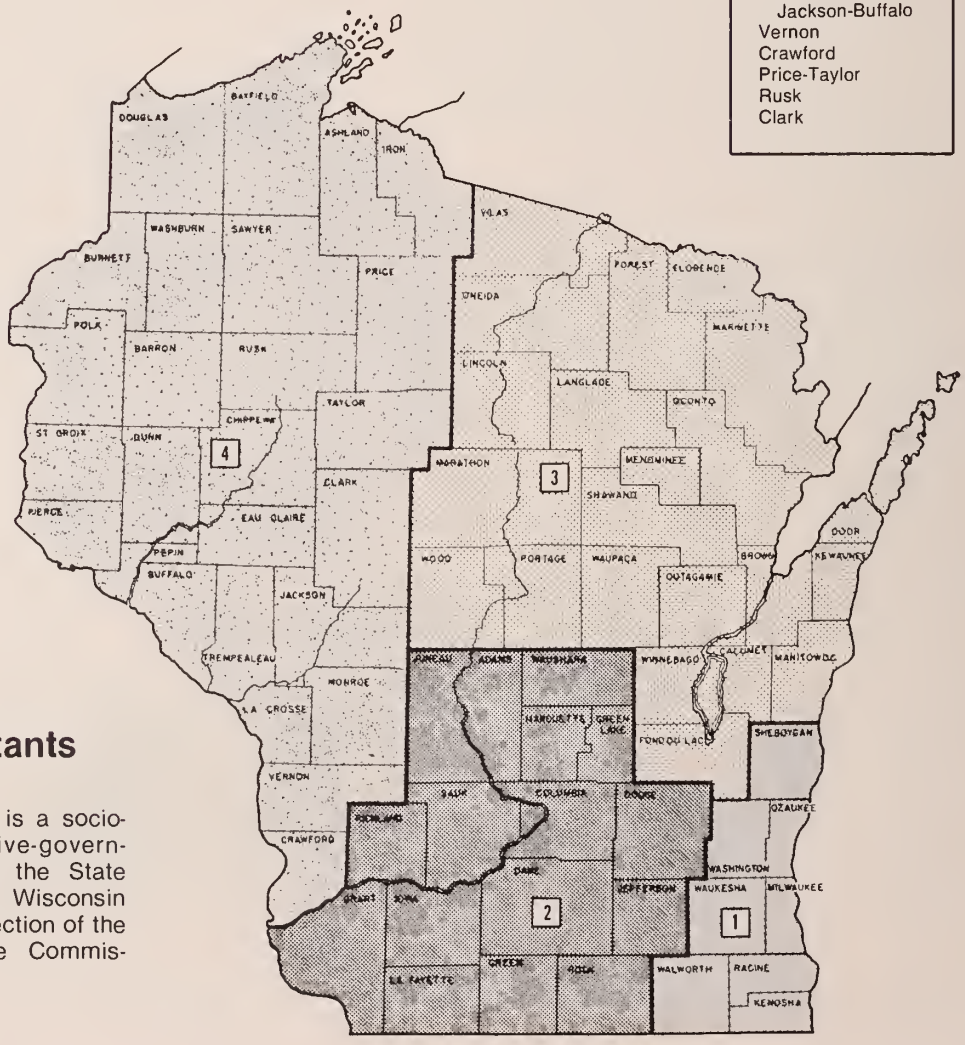
DISTRICT 4
Paul Jacobson
(715/874-6125)

County medical societies

Ashland-Bayfield-
Iron
Douglas
Barron-Washburn-
Burnett
Sawyer
Polk
Pierce-St Croix
Chippewa
La Crosse
Monroe
Eau Claire-Dunn-
Pepin
Trempealeau-
Jackson-Buffalo
Vernon
Crawford
Price-Taylor
Rusk
Clark

1985 Physicians Alliance Districts and Field Consultants

Physicians Alliance is a socio-economic-legislative-governmental division of the State Medical Society of Wisconsin and is under the direction of the Physicians Alliance Commission.



WISCONSIN UNIFORM INSURANCE CLAIM FORM can be ordered direct from SMS Services

- Claim form approved by DHSS and EDS Federal for Wisconsin Medical Assistance Program (WMAP) claims.
- Accepted by all major insurance carriers.
- Form costs one third less than its national competitor.
- Available in two-part snapout and one- or two-part continuous form.
- Forms will be shipped to you within 48 hours after order received.

Place your order with SMS Services, Inc, 330 East Lakeside Street, PO Box 1109, Madison, Wisconsin 53701; or phone (608) 257-6781 or toll-free in Wisconsin (800) 362-9080.

Wisconsin Physicians Political Action Committee (WISPAC)

The Wisconsin Physicians Political Action Committee is a voluntary, nonprofit organization whose membership consists of physicians and their spouses. Restricted from making political contributions, the State Medical Society created and administers WISPAC to provide the medical profession with an opportunity to assume a more active and effective role in the political process. WISPAC traditionally concentrates on state legislative races and cooperates with the American Medical Political Action Committee, AMPAC, on the national level.

1983-85 WISPAC Board of Directors

William Treacy, MD, Chairman, Milwaukee
Michael Mehr, MD, Vice Chairman, Marshfield
John K Scott, MD, Treasurer, Madison
Sandra Osborn, MD, Assistant Treasurer, Madison

* * *

Jay Schamberg, MD, Menomonee Falls
DeLore Williams, MD, West Allis
Thomas Dehn, MD, Bayside
Irvin Bruhn, MD, Walworth
Carl Eisenberg, MD, Milwaukee
LaVern Herman, MD, Waukesha
William Listwan, MD, West Bend
Daniel Forward, MD, Wauwatosa
Charles Pechous, MD, Kenosha
Donald Vangor, MD, Baraboo
Mel Blumenthal, MD, Monroe
Robert McDonald, MD, Madison
Glenn Seager, MD, La Crosse
Bruce Hertel, MD, Rhinelander
Kenneth Day, MD, Wausau
Henry Chessin, MD, Appleton
Michael Tieman, MD, Berlin
John Beck, MD, Sturgeon Bay
James Mattson, MD, Green Bay
Paul Haskins, MD, River Falls
Arlyn Koeller, MD, Ashland
Chesley Erwin, MD, Milwaukee
Timothy Flaherty, MD, Neenah
Kenneth Viste, MD, Oshkosh
J D Kabler, MD, Madison
Charles Picard, MD, Superior
Mrs Bea Kabler, Madison
Mrs Jeri Cushman, Racine
Mrs Roberta Baldwin, Watertown
Mrs Ann Shea, De Pere

Membership—Membership contributions may be sent to:

WISPAC
PO Box 2595
Madison, WI 53701
(608) 257-6781

Suggested membership categories include:

$100 Sustaining Membership
$ 80 Family Membership (physician/spouse)
$ 40 Regular WISPAC/AMPAC
$ 20 Regular WISPAC ■

COUNTY MEDICAL SOCIETIES

President (P) and Secretary (S); Executive Secretary (ES), Treasurer (T); Executive Vice President (EVP); Executive Assistant (EA); Assistant Secretary (AS); and telephone numbers

ASHLAND-BAYFIELD-IRON
P—Mark K Belknap, MD
922 Second Avenue, West
Ashland, WI 54806
(715) 682-6651
S—David M Saarinen, MD
2101 Beaser Avenue, #2
Ashland, WI 54806

BARRON-WASHBURN-BURNETT
P—Donald E Riemer, MD
PO Box 127
Cumberland, WI 54829
(715) 822-2231
S—Roger F Macy, MD
PO Box 127
Cumberland, WI 54829
(715) 822-2231

BROWN
P—James R Mattson, MD
501 S Military Avenue
Green Bay, WI 54303
S—Stephen D Hathway, MD
PO Box 1700
Green Bay, WI 54305
(414) 433-3653
T—Roger C Wargin, MD
613 Ridgeview Court
Green Bay, WI 54303
(414) 499-8859

CALUMET
P—Randy T Theiler, MD
451 East Brooklyn Street
Chilton, WI 53014
S—William E Hannan, MD
614 Memorial Drive
Chilton, WI 53014

CHIPPEWA
P—Richard C Sazama, MD
3203 Stein Blvd
Eau Claire, WI 54701
(715) 835-6548
S—Robert S Lea, MD
1102 Dover Street
Chippewa Falls, WI 54729

CLARK
P—Vangala J Reddy, MD
216 Sunset Place
Neillsville, WI 54456
(715) 743-3101
S—Rupa Chennamaneni, MD
216 Sunset Place
Neillsville, WI 54456
(715) 743-3231

COLUMBIA-MARQUETTE-ADAMS
P—Donald J Taylor, MD
1015 West Pleasant Street
PO Box 387
Portage, WI 53901
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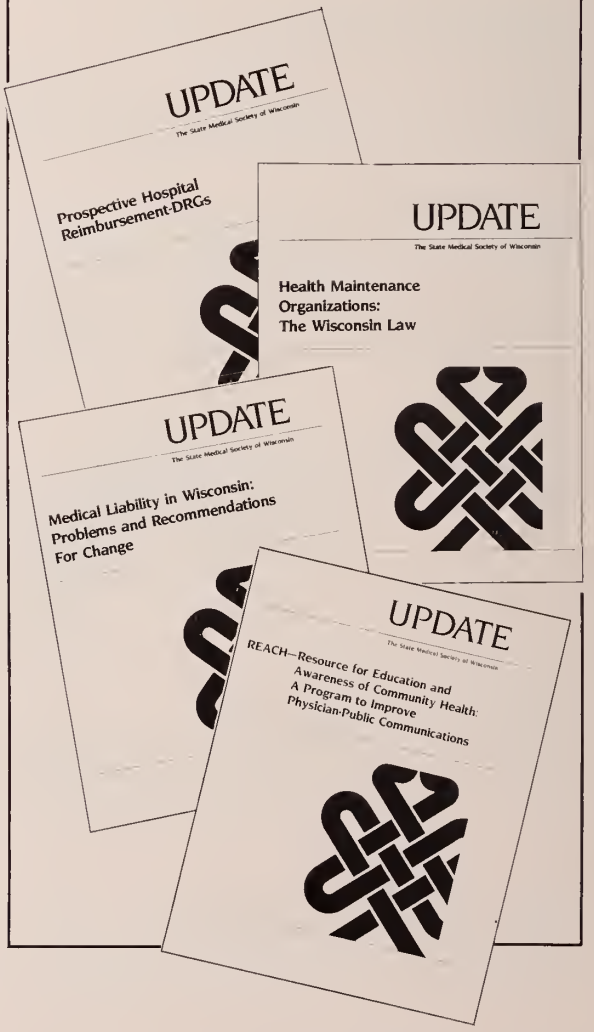
SMS Members!

In late 1983 the State Medical Society launched a publication series called ***Update*** to provide members with issue-specific background papers that examine subjects in greater depth than is permitted by the more traditional SMS publications. These special publications not only provide background information on an issue but also advise all members of the plans, strategies, and recommendations of the Society as it confronts these issues. Four editions of ***Update*** have been published: *Prospective Hospital Reimbursement-DRGs, Health Maintenance Organizations: The Wisconsin Law, Medical Liability in Wisconsin: Problems and Recommendations for Change, and REACH—Resource for Education and Awareness of Community Health: A Program to Improve Physician-Public Communications.* Members are urged to retain these ***Updates*** for future reference. New members who would not have received these issues are particularly urged to contact the SMS Secretary's Office for their copies.



BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

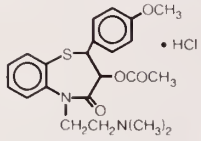
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 00088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 00088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 00088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 00088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Motrin®
ibuprofen, Upjohn
600 mg Tablets

More convenient for your patients.

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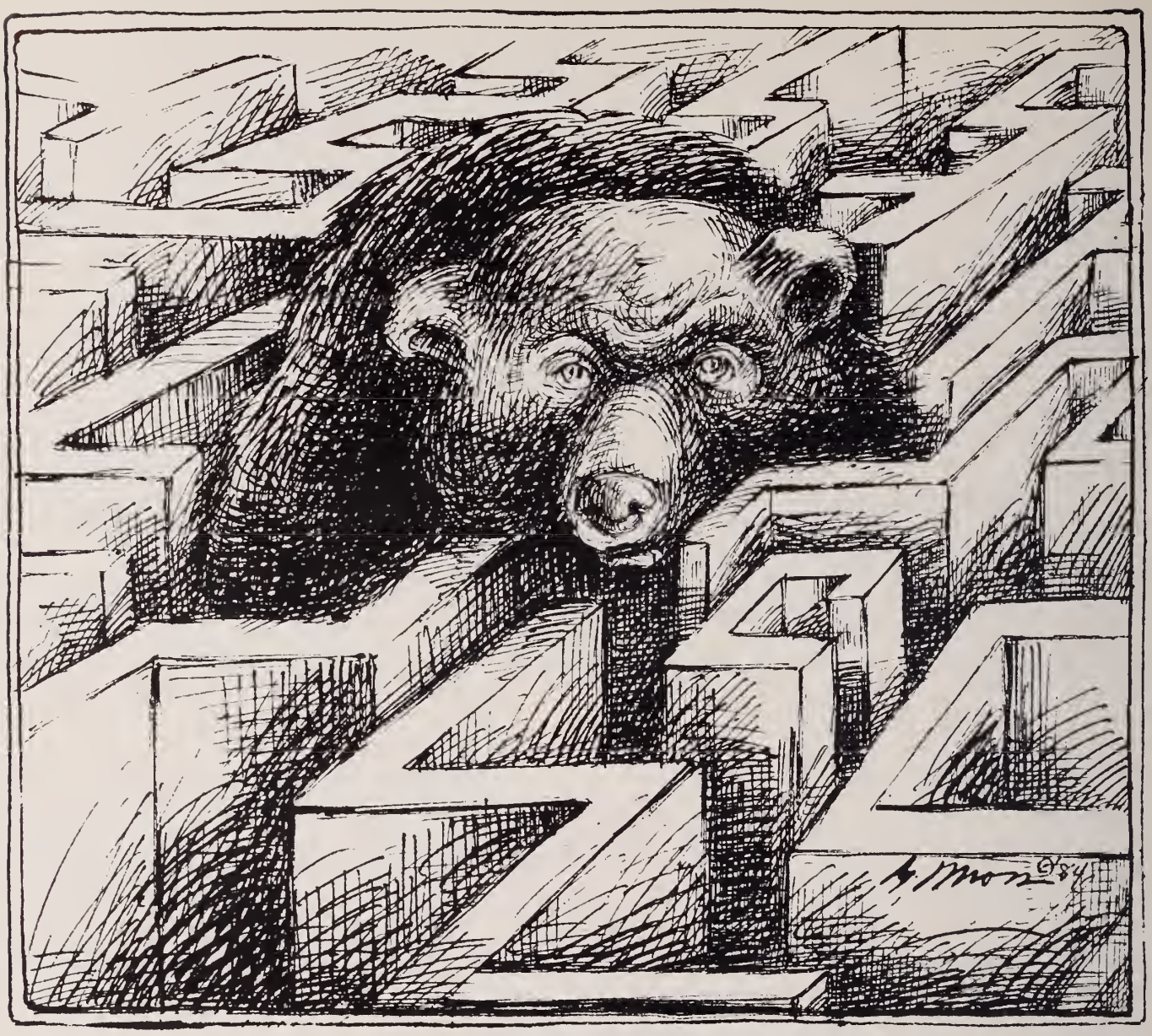
J-4044 January 1984



Outsmarting The Bear.

You never know when you'll run into the bear on Wall Street. But when the bull gets sluggish and rates decline, you'll know he's around. And large investors may have cause to worry.

The bear can be mean, but there is a way to outsmart him. Just join the Payroll Savings Plan and buy U.S. Savings Bonds.

Bonds have a variable interest rate so you can share in the higher returns during a *bull* market. There's no limit on how much you can earn.

But suppose it turns into a *bear* market? Now you're protected by a guaranteed minimum, no matter how fierce the bear turns.

So, no need to run, fight or hide from the bear. The smartest move you can make is the move to U.S. Savings Bonds.

Take stock in America.

UNITED STATES ★ SAVINGS BONDS ★

Ad Council A Public Service of This Publication

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L39

In Hypertension*... When You Need to Conserve K^+

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Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)

Potassium-Sparing DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 19 Years of Confidence

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On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions*.) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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Patricia Kallsen 266-1281
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ASSISTANT ADMINISTRATOR for Public Health Services
William Schmidt

ASSISTANT ADMINISTRATOR for Health Administration
John Chapin

OFFICE OF MANAGEMENT AND POLICY
Dave Mills

BUREAUS

Planning & Development ... 266-2020

- Staffing of Health Policy Council and its committees
- Development of State Health Plan
- Liaison with Health Systems Agencies and review of their plans and budgets
- Coordination of categorical health planning process
- Review of categorical health plans
- Liaison with agencies (public and private) that implement the State Health Plan
- Service licensure
- Development of health facilities plan
- Review of categorical grants appeal

Health Care Financing 266-2522

- Administration of the Medical Assistance Program
- EPSDT—Early and periodic screening, diagnosis and treatment for children and other screening activities

Quality Compliance 266-8847

- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards

Community Health & Prevention 266-1251

- Development and promotion of prevention programs
- Standard epidemiology
- Environmental epidemiology
- Immunization activities
- Communicable diseases
- Chronic diseases
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Laboratory certification
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning

Correctional Health Services 266-5718

- Assurance of sufficient levels of physical health care for all inmates in correctional institutions and at Central State Hospital
- Management of the provision of such services to insure effectiveness and efficiency
- Recruitment and staffing of health care positions in the correctional institutions

Environmental Health 266-9377
(1400 E Washington Ave, Madison 53702)

- Certification of Grade A milk
- Inspection of hotels, restaurants and food vending services where not performed by local public health agencies
- General environmental sanitation
- Recreational inspection
- Radiation protection
- Occupational health services
- Development of emergency medical services systems

Health Statistics 266-1939

- Vital Statistics
- Resource data
- Demographic and special analysis
- Services data

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Tel 608/249-8928

MILWAUKEE 53202
819 North 6th St, Rm 860
Tel 414/224-4860

GREEN BAY 54301
200 N Jefferson
Tel 414/497-3219

EAU CLAIRE 54701
Eau Claire State Office Building, 136
718 W Clairemont Ave
Tel 715/836-5362
Tel 715/836-4752 (Long Term Care)

RHINELANDER 54501
1853 N Stevens St; PO Box 1165
Tel 715/362-7800

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William Griffin

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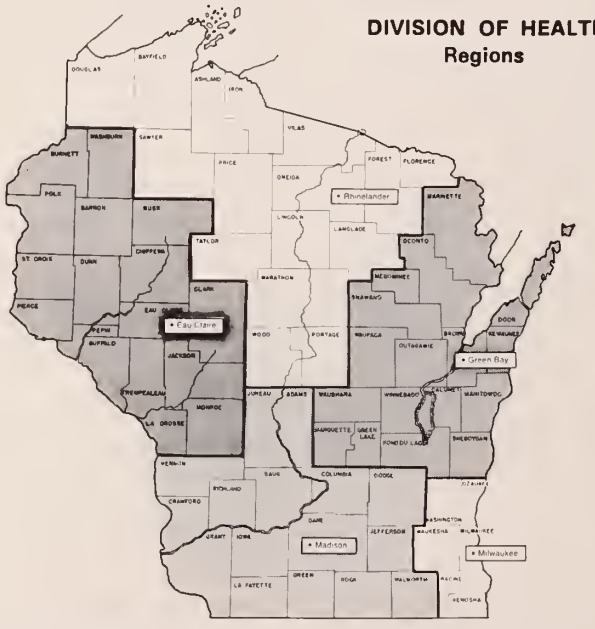
STAFF: David E Joranson, Controlled Substances Policy Specialist, Controlled Substances Board, Bureau of Community Programs, Department of Health and Social Services, 1 West Wilson St, PO Box 7851, Madison, Wis 53707 (ph 608/266-7586)



Center for Health Statistics Division of Health

The Center is the custodian of birth, death, marriage and divorce records for the state (ss. Chapter 69). Also, the Center has a contract with the National Center for Health Statistics for collection of vital statistics and partial funding from the Health Care Financing Administration for the collection of data on hospital discharge, health manpower, and health facilities. Several other projects are being carried out in areas such as cancer reporting, blood alcohol reporting. Another of the Center's activities is the production of annual population estimates for Wisconsin counties...a part of the Federal-State Cooperative Program of the Bureau of the Census. Inquiries may be made to: Raymond D Nashold, Director, Center for Health Statistics, PO Box 309, Madison, WI 53701.

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continued next page

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Health Policy Council

The Governor's Health Policy Council is the chief health policy advisory body in the state and is primarily responsible for the coordination of the five area health systems plans into what ultimately becomes the triennial State Health Plan. The Council also advises the Department of Health and Social Services staff on major health issues and periodically reviews various statewide plans for the use of Federal grant health funds. In 1982 two Health Systems Agencies—the Northeastern Agency and the Lake Winnebago Agency—disbanded. This removed eight (8) HSA seats on the Council. Since state law requires a 60% HSA to 40% Governor at-large ratio on the Council, the at-large seats were reduced by four (4). The Council now has a total of 35 members—20 HSA-nominated representatives, 14 at-large representatives, and 1 ex-officio VA representative.

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Tel 608/788-0027

Vice Chairman, HPC
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*Ex-officio Member ■

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  - What is a Medicare Supplement policy?
  - How do different policies compare in coverage? In cost?
  - What policies are currently on the market?
- **Health insurance for those over 65**
  - Do I have good health care coverage?
  - Am I paying for too much insurance?
  - Can I replace my policy with a better one?
- **Special kinds of health insurance**
  - Are cancer policies worthwhile?
  - How do indemnity policies work?
  - Do I need a nursing home policy?
- **Medical Assistance (Medicaid, M.A., Title XIX)**
  - Am I eligible for Medical Assistance?
  - Do I need private insurance with M.A.?
  - What does M.A. cover?
  - Where do I apply?

Medigap Hotline is a project of the Center for Public Representation in Madison. It is available to Wisconsin residents over age 65 or approaching retirement. When the Hotline is not in operation, a recording will give the scheduled times for calling.

WISCONSIN HEALTH SYSTEMS AGENCIES

(listed by district and serving the counties therein)

Federally designated, the seven Wisconsin HSAs are primarily responsible for areawide and regional health planning and resource development activities in their respective health service areas. Either public or private nonprofit entities, the consumer dominated HSAs (1) formulate Health Systems Plans; (2) initially review Certificate of Need Applications for institutional health services, equipment, and construction; (3) perform the first phase of Federally required "Appropriateness Review"; and (4) serve as a screening body for the application of Federal Health Funds. Additionally, HSAs are charged with the mandate to overcome access barriers to treatment, avoid duplication of service, and generally strive towards the improved health of area residents.

District 1: **Health Planning Council, Inc (HPC)**, 995 Applegate Road, Madison 53713
Joyce Mevis, President
Paul Fleer, Executive Director (Ph 608/273-1809)
Counties: Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, LaFayette, Richland, Rock, Sauk

District 2: **Southeastern Wisconsin Health Systems Agency, Inc (SEWHSA)**, 735 W Wisconsin Ave, #600, Milwaukee, Wisconsin 53233
Matthias Goebel, President
Kipton Kaplan, Executive Director (Ph 414/271-9788)
Counties: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha

District 3: **Lake Winnebago Area Health Systems Agency, Inc (LWAHSA)** DHSS currently is performing functions since closing of this district office July 1982.
Counties: Calumet, Fond du Lac, Green Lake, Marquette, Outagamie, Waupaca, Waushara, Winnebago

District 4: **Northeastern Wisconsin Health Systems Agency, Inc (NEWHSA)** DHSS currently is performing functions since closing of this district office July 1982.
Counties: Brown, Door, Kewaunee, Manitowoc, Marienette, Menominee, Oconto, Shawano, Sheboygan

District 5: **Western Wisconsin Health Systems Agency, Inc (WWHSA)**, 907 Main Street, La Crosse, Wisconsin 54601
Sandra McCormick, President
Val Chilsen, Executive Director (Ph 608/785-9352)
Counties: Barron, Buffalo, Chippewa, Clark, Crawford, Dunn, Eau Claire, Jackson, LaCrosse, Monroe, Pepin, Pierce, Polk, Rusk, St. Croix, Trempealeau, Vernon

District 6: **North Central Area Health Planning Association, Inc (NCAHPA)** 408 Third St, #202, Wausau, Wisconsin 54401
Archie Becker, President
George Snyder, Executive Director (Ph 715/845-3107)
Counties: Adams, Florence, Forest, Juneau, Langlade, Lincoln, Marathon, Oneida, Portage, Taylor, Vilas, Wood

District 7: **Health Systems Agency of Western Lake Superior, Inc** Ordean Building, Suite 202, 424 W Superior Street, Duluth, Minnesota 55802
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Jerry J Noren, MD, 610 N Walnut, Madison 53705

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Southeastern Wisconsin Health Systems Agency, Inc
*Carl S L Eisenberg, MD, 3003 W Good Hope Rd, Milwaukee 53217

District 3
(No office) (Responsibility of the Division of Health)

District 4
(No office) (Responsibility of the Division of Health)

*Denotes member of SMS

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*Lowell A Kristensen, MD, 1020 Lakeshore Dr, Rice Lake 54868
*Joseph M Tobin, MD, Box 224, Eau Claire 54701
*Joseph B Durst, MD, 815 South 10th St, La Crosse 54601
*Donald E Hoff, MD, UW-Eau Claire, Student Health Service, Eau Claire 54701

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*Harold J Kief, MD, Rt #1, Box 1502, Rhinelander, 54501
*William J Mauer, MD, 1311 Lincoln Ave, Marshfield, 54449

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*Harold B Leppink, MD, 504 East Second St, Duluth, MN 55805 ■

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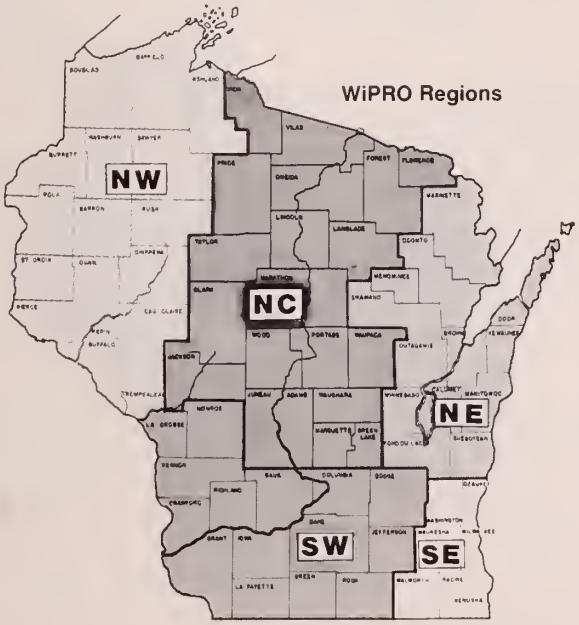
Greg E Simmons, Chief Operating Officer, 756 N Milwaukee St, Milwaukee 53202

Southwest Regional Manager, Robert K Rogers, 330 East Lakeside, Madison 53705
Southeast Regional Manager, Mike Rode, 756 N Milwaukee St, Milwaukee 53202
North Central Regional Manager, Jon Griffith, 2404 Stewart Square, Suite C, Wausau 54401
Northeast Regional Manager, Richard Priest, 2301 Riverside Dr, Green Bay 54301
Northwest Regional Manager, Scott Layman, 405 S Farwell St, Suite 16, Eau Claire 54701



Southwest Regional Review Committee

John A Austin, MD, 5480 North Washington, Janesville, WI 53545 (608/755-3500)
Neil N Bard, MD, 1313 Seminary St, Richland Center, WI 53581 (608/647-6161)
James W Bayuk, MD, 1836 South Ave, La Crosse, WI 54601 (608/782-7300)
Richard A Damon, MD, 130 Warren St, Beaver Dam, WI 53916 (414/885-4433)
David D Gregory, MD, 910 Silver Lake Dr, Portage, WI 53901 (608/742-7161)
Roy S Horras, MD, 202 North Gammon Rd, Madison, WI 53717 (608/251-2371)
David P Kuter, MD, 703 14th St, Baraboo, WI 53913 (608/356-6656)
Robert A Starr, MD, 318 W Decker St, Viroqua, WI 54664 (608/637-3175)
Philip H Utz, MD, 700 West Ave, South, La Crosse, WI 54601 (608/785-0940)

Southeast Regional Review Committee

Gerald J Dorff, MD, 12011 West North Ave, Wauwatosa, WI 53226 (414/771-8228)
Joseph E Geenen, MD, 1333 College Ave, Racine, WI 53403 (414/637-7996)
Michael F Gorczynski, DO, 9330 West Greenfield, Milwaukee, WI 53214 (414/771-2177)
Lee Huberty, MD, 6530 Sheridan, Kenosha, WI 53140 (414/658-1349)
Michael J Mally, MD, 1004 East Sumner, Hartford, WI 53027 (414/673-5745)
Jane L Neumann, MD, 725 American Ave, Waukesha, WI 53186 (414/544-2011)
Archebald R Pequet, MD, 10425 West North Ave, Wauwatosa, WI 53226 (414/453-3420)
David Y Rosenzweig, MD, 8700 West Wisconsin Ave, Milwaukee, WI 53226 (414/257-6355)
Richard Stone, MD, 227 East Silver Spring Dr, Milwaukee, WI 53217 (414/961-2020)

Northwest Regional Review Committee

F D Cook, MD, 2661 County Trunk "I", Chippewa Falls, WI 54729 (715/723-1811)
Michael F Finkel, MD, 733 West Clairemont Ave, Eau Claire, WI 54701 (715/839-5203)
A A Koeller, MD, 206 6th Ave, West, Ashland, WI 54806 (715/682-6622)
Randall Linton, MD, 733 West Clairemont Ave, Eau Claire, WI 54701 (715/839-5201)
Carrie Nelson, MD, Elmwood, WI 54740 (715/639-4151)
Leo K Nelson, MD, 208 Adams St, South, St Croix Falls, WI 54024 (715/483-3221)
James A Rugowski, MD, 733 West Clairemont Ave, Eau Claire, WI 54701
C Malcom Scott, MD, 318 21st Ave, Superior, WI 54880 (715/389-3561)
David M Woeste, MD, 409 Spruce St, River Falls, WI 54022 (715/425-6701)

Northeast Regional Review Committee

Blaine W Claypool, MD, 424 East Longview Dr, Appleton, WI 54911 (414/739-4241)
Hugh F DeMorest, MD, 502 Surrey Lane, Neenah, WI 54956 (414/725-1269)
Robert E Johnson, MD, 1551 Dousman, Green Bay, WI 54303 (414/494-5611)
Donald H McDonald, MD, 19 South 3rd St, Winneconne, WI 54986 (414/582-4481)
Robert H Mikkelsen, MD, 10 Forest Ave, Fond du Lac, WI 54935 (414/921-7000)

continued next page

Jonathan V Moulton, MD, 1011 North 8th St, Sheboygan, WI 53081 (414/457-4461)
David A Satchell, MD, 600 York St, Manitowoc, WI 54200 (414/682-0181)
Thomas W Schueppert, MD, 345 South 18th Ave, Sturgeon Bay, WI 54235
Joseph W Weber, MD, 525 High St, New London, WI 54961 (414/982-3421)

North Central Regional Review Committee

Daniel Brick, MD, 2501 Main St, Stevens Point, WI 54481
Norman Desbiens, MD, 1000 North Oak Ave, Marshfield, WI 54449 (715/387-5177)
Alonzo Giminez, MD, 270 E Marquette St, Berlin, WI 54923 (414/361-1838)
Bahri Gungor, MD, 216 Sunset Place, Neillsville, WI 54456
Peter Hamel, MD, Rte 4, Box 191, Waupaca, WI 54981
Charles A Heuss, MD, 1111 Langlade Rd, Antigo, WI 54409 (715/623-3761)
Kim Hilliker, MD, Hemlock St, Box 470, Woodruff, WI 54568 (715/356-8000)
Rick Reding, MD, 2800 Westhill Dr, Wausau, WI 54401 (715/848-2811)
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SCHOOL ATTENDED/ATTENDING _____

GRADUATION DATE _____ DEGREE _____

SPECIALTY AREA OF INTEREST _____

Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1985 are $455 for SMS, $330 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin
DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Your membership in organized medicine will help insure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1985 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1985 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455	$330	Normal County Dues
Resident	45.50	45	Varies
Military Service	-0-	220 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	227.50	330*	Normal County Dues
Over Age 70	227.50	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	20	Varies
Sophomore and Succeeding Medical Student Years	10	20	Varies
Postgraduate—One	10	45	Varies

*Physicians in the following categories may be eligible for exemption from paying AMA dues: (1) Financial hardship and/or disability, (2) Age 65-69 and retired from the practice of medicine, (3) Over age 70 *regardless* of retirement status.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

Doctor Scott installed SMS president

John K Scott, MD, Madison, was installed as the 1985-86 president of the State Medical Society during its Annual Meeting in La Crosse, April 25-27. He succeeds Timothy T Flaherty, MD of Neenah.

Doctor Treffert and Doctor Scott

Top priorities: Malpractice reform, membership

Outgoing President Timothy T Flaherty, MD, in his address to the House of Delegates during the Annual Meeting, reminded his colleagues that the top two priorities for organized medicine are malpractice reform and membership. "Our strength lies in our unity and every physician must recognize the need to be unified," he said. "We, as individual physicians and as an organization of physicians, must continue to do what is best for the patients of Wisconsin; and I am confident this will always prove best for the physicians of Wisconsin."

The full text of his address appears elsewhere in this issue.■

Doctor Scott, an otolaryngologist-head and neck surgeon, is a clinical professor of surgery at the University of Wisconsin Medical School and is a preceptor for the fourth-year residency program at Madison General Hospital. A complete biographical sketch appeared in the May issue.

In his address to the House of Delegates, April 25, Doctor Scott said physicians must be advocates for patients. "Despite the innumerable government regulations and competitive schemes we have today, the truest guardian of good patient care remains the physician with a good conscience," he said. Full text of his address appears elsewhere in this issue.■

Election results

The House of Delegates April 26 reelected Duane W Taebel, MD, La Crosse, speaker of the House and John J Foley, MD, Menomonee Falls, as treasurer of SMS.

Reelected to serve as delegates to the American Medical Association for 1986 and 1987 were Henry F Twelmeyer, MD, Wauwatosa; Richard W Edwards, MD, Richland Center, and Cornelius A Natoli, MD, La Crosse. Timothy T Flaherty, MD, Neenah, was elected a delegate for 1985.

The House also confirmed the election of 11 physicians to the Society's Board of Directors. Reelected to the Board were: Jerome W Fons Jr, MD, Milwaukee; Cyril M Hetsko, MD, Madison; J D Kabler, MD, Madison; James J Tydrich, MD, Richland Center; Jung K Park, MD, Wisconsin Rapids, and Darold A Treffert, MD, Fond du Lac. Elected to the Board were Glenn H Franke, MD, Milwaukee, Lucille B Glicklich, MD, Milwaukee; Kenneth I Gold, MD, Beloit; Joseph C DiRaimondo, MD, Manitowoc, and Philip J Happe, MD, Eau Claire.■

NEW DIRECTORS

District 1

Glenn H Franke, MD, Milwaukee

Born on June 9, 1928 in Milwaukee, Doctor Franke graduated from Northwestern University School of Medicine in 1953 and completed his internship and residency at Columbia Hospital in Milwaukee. He served in the United States Navy from 1954-1956. Doctor Franke served as president of The Medical Society of Milwaukee County in 1982. He is a member of the SMS Committee on Medicine and Religion and the Committee on Alcoholism and Other Drug Abuse. Doctor Franke was elected to the Board of Directors in April 1985, for a three-year term.

District 1

Lucille B Glicklich, MD
Milwaukee

Born on January 10, 1926 in Fond du Lac, Doctor Glicklich graduated from the University of Wisconsin Medical School, Madison, in 1950. Her internship was served at Youngstown Hospital Association, Ohio, and her pediatric residency was completed at Milwaukee Children's Hospital. Her psychiatric residency was completed at the VA Hospital, Wood, and at Milwaukee Children's Hospital. Doctor Glicklich is a member of the SMS Commission on Public Information. She is serving

as president of The Medical Society of Milwaukee County for the year 1985. Doctor Glicklich was elected to the Board of Directors in April 1985 to fill the unexpired term (1984-1987) of Charles W Landis, MD.

District 2

Kenneth I Gold, MD, Beloit

Born in New York, New York, on April 16, 1937, Doctor Gold graduated from the State University of New York-Downstate Center, Brooklyn, in 1961. His internship and residency were completed at University Hospitals, Columbus, Ohio. Doctor Gold served in the United States Navy from 1963-1965. He is a member of the SMS Commission on Continuing Medical Education. Doctor Gold served as president of the Wisconsin Society of Internal Medicine in 1980. He was licensed to practice medicine in Wisconsin in 1968. Doctor Gold was elected to the Board of Directors in April 1985 for a three-year term.
for a three-year term.

District 6

Joseph C DiRaimondo, MD Manitowoc

Born July 14, 1939 in Rockford, IL, Doctor DiRaimondo graduated from Washington University School of Medicine, St Louis, MO, in 1965. His internship and residency were completed at University Hospitals (now UW Hospital and Clinics), Madison. Doctor DiRaimondo was licensed to practice medicine in Wisconsin in 1966. He has served on the SMS Physicians Alliance Commission since 1978. Doctor DiRaimondo was elected to the Board of Directors in April 1985 for a three-year term.

District 7

Philip J Happe, MD, Eau Claire

Born on May 13, 1938 in Minneapolis, MN, Doctor Happe graduated from Creighton University Medical School, Omaha, NB, in 1964. His internship was served at Ancker Hospital (St Paul Ramsey) St Paul, MN, and his residency was completed at Creighton University Affiliated Hospitals in Nebraska. Doctor Happe served in the United States Air Force from 1965-1967 and was licensed to practice medicine in Wisconsin in 1970. Doctor Happe was elected to the Board of Directors in April 1985 to fill an additional position for District 7.■

Doctor Charles Landis, Milwaukee, is president-elect

Charles W Landis, MD, Milwaukee, was elected president-elect of the State Medical Society during its Annual Meeting in La Crosse, April 25-27.

A graduate of Indiana University School of Medicine, Doctor Landis served his internship at the University of Oregon and his psychiatric residency at Indiana University. In 1958 he became certified by the American Board of Psychiatry and Neurology.

Currently medical director and chief-of-staff at St. Mary's Hill Hospital in Milwaukee, he also maintains a private psychiatric practice.

The new president has been active at all levels of organized medicine. A past president of the Medical Society of Milwaukee County, Doctor Landis has been a member of its Board of Directors since 1980.

At the state level, he has been a member of the SMS Board of Directors since 1984 and has been a member of the Society's House of Delegates. His committee involvements include serving as a member or chairman of the Society's Committee on Mental Health since 1978, and serving as a member of the Committee on Alcoholism and Other Drug Abuse.

Doctor Landis is a member and past president of the Wisconsin Psychiatric Association as well as a member of the American Psychiatric Association, Milwaukee Neuropsychiatric Society, and the American College of Psychiatry.

Doctor Landis has served on boards or as a member of a number of civic, governmental, and professional organizations. Presently, he is on the Board of Directors of the United Way of Greater Milwaukee and is a member of the Milwaukee Rotary Club. In 1983 he received the Milwaukee County Executive Proclamation honoring him for community service.■

Doctor Landis

Board of Directors April meeting highlights

In action April 24 and 27 during the Annual Meeting in La Crosse, the SMS Board of Directors:

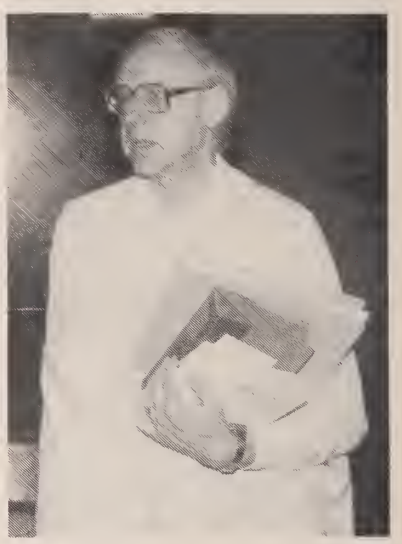
• Voted to consolidate the membership and activities of the Commission on Governmental Affairs and the Physicians Alliance Commission. This "new" commission is charged with the responsibility for the formulation of Society policy, subject to Board and House of Delegates review, in the broad areas of legislation, political action, and socio-economic issues. Current members of the two commissions are being contacted as to whether they wish to serve on the new commission.

• Received an update on SMS membership and directed the membership committee to look at incentives for early payment of dues.

• Made a number of appointments to SMS commissions and committees. These appointments appear elsewhere in this issue.

• Reelected Darold A Treffert, MD, Fond du Lac, chairman of the Board for 1985-86; Roger L von Heimburg, MD, Green Bay, vice chairman; Eugene J Nordby, MD, Madison, and William T Russell, MD, Sun Prairie, assistant treasurers. William P Crowley, MD, Madison, was appointed an assistant treasurer and Earl R Thayer, Madison, was reelected secretary and general manager.

• Reelected Wayne J Boulanger, MD, Milwaukee, editorial director and Victor S Falk Jr, MD, Edgerton, medical editor of the *Wisconsin Medical Journal.* Russell F Lewis, MD, Marshfield, and Raymond A McCormick, MD, Green Bay, were reelected and R Buckland Thomas, MD, Monroe, was elected as editorial associates of WMJ. Andrew B Crummy Jr, MD, Madison, was elected to the Editorial Board.



Doctor Treffert
A long, hard day. . .

George W Kindschi, MD, Monroe, was reelected to the Editorial Board.

• Set the following Board meeting dates for 1985 and 1986: June 29, 1985; August 24, 1985; October 25, 1985 (Leadership Conference October 26); December 14, 1985; March 1, 1986 and April 16, 1986 in Milwaukee during the 1986 SMS Annual Meeting.

• Reappointed John J Kief, MD, Rhinelander, as the at-large member on the Executive Committee.

• Changed the SMS policy concerning candidate membership benefits to include monthly copies of the *Wisconsin Medical Journal.*■

New Editorial Board member

Andrew B Crummy Jr, MD, Madison, was appointed to the Editorial Board of the *Wisconsin Medical Journal* by the SMS Board of Directors at its meeting during the Annual Meeting, April 25-27, in La Crosse. He succeeds Wayne J Boulanger, MD, Milwaukee, who completed his third 3-year term thus was ineligible for reappointment.

Doctor Crummy

Doctor Crummy is a 1955 graduate from Boston University Medical School and completed his residency in radiology at University Hospitals (now UW Hospital and Clinics), Madison. He was licensed to practice medicine in Wisconsin in 1958. He joined the medical faculty of the University of Wisconsin Medical School in 1963 and is a full professor. He served as president of the Wisconsin Radiological Society in 1972-1973.

The Board of Directors also reappointed George W Kindschi, MD of Monroe to the Editorial Board.■

SMS Secretary issues call for tougher peer review

Warning that the State Medical Society must not "pull into its professional shell" because it doesn't have the ultimate authority for disciplining state physicians, SMS Secretary and General Manager Earl R Thayer April 25 called upon the Society to immediately engage in a vigorous, organized, and public effort to deal with the incompetent or aberrant physician. *continued*

In his report to the Society's House of Delegates, Thayer urged the House to appoint a special task force of SMS members to work on a series of reforms to reduce malpractice.

Among the reforms suggested by Secretary Thayer to improve the Medical Examining Board's and the Society's efforts in disciplining doctors were:

- Encouraging the Governor in his appointments to the Board to look for "quality of person and practice character, not quantity of political contribution" as the primary criterion.
- Expanding the Board by two or three physicians and authorizing it to delegate certain physician-care review functions to contracted physicians in various parts of the state.
- Providing civil immunity without restriction to any physician who acts in good faith in reporting alleged inappropriate medical care or practice.
- Establishing, together with the Patient's Compensation Fund and all malpractice insurance carriers, a coordinated malpractice-incident reduction program.
- Urging the Society's endorsed medical liability company, as well as others, to "seriously consider mandatory participation in risk-management programs" as a condition for an individual physician to get malpractice insurance.
- Establishing a system for data collection and analysis of all medical liability claims including claims settled at any stage.
- Improving credentialing and peer review processes of hospital medical staffs.
- Integrating into the entire peer review process the findings of WiPRO and similar peer review efforts undertaken on a private basis.
- Initiating immediate discussions with the Medical Examining Board, the Wisconsin Justice Department, independent attorneys, and legislators to seek a remedy to a legal process which "seems so easily manipulated to save the bad doctor."

"We cannot afford to wait for someone else to start the action," Secretary Thayer said. "The integrity of our dedicated physicians is at stake. The public says this is your job, your responsibility. They may not be totally correct, but they are not totally wrong either."

The full text of his address appears elsewhere in this issue.■

Some controls needed

Addressing the SMS House of Delegates during its Annual Meeting April 25-27 in La Crosse, newly-appointed AMA Senior Deputy Executive Vice President James S Todd, MD told Wisconsin physicians that they are not alone in facing a malpractice crisis. He said some controls on doctors are needed to help solve the malpractice problem. "Satisfied patients don't sue," he stressed. Doctor Todd highlighted the AMA's four-point program for dealing with the issue which includes: 1) more internal monitoring and discipline, 2) coordination of legal defense activities, 3) reform of laws, and 4) public education on the dangers of the liability system.■

James S Todd, MD

House of Delegates Highlights . . .

The SMS House of Delegates had a full agenda April 25 and 26 when it met in La Crosse for its Annual Meeting. Among the issues the House grappled with were:

Task Force on Medical Care—Referred the entire report to the Board of Directors for review, implementation, and report or return to the House of Delegates for action as necessary.

Peer Review—Called for the appointment of a task force to coordinate the Society's work in discipline and peer review with the current efforts of the state Legislature and the Medical Examining Board.

Medical Liability—Will ask the AMA to undertake an international study on solutions to the medical liability problem.

CON/CER—Will continue to seek repeal of the certificate-of-need/capital expenditure review law.

Cost Containment—Requested that insurance companies pass the results of cost containment on to the citizens of Wisconsin in the form of lower premiums.

Boxing—Will seek legislation supporting the abolition of amateur and professional boxing in the state of Wisconsin and that the State Medical Society educate the public concerning the dangerous aspects of boxing.

continued

Smokeless Tobacco—Supported placement of an "injurious to health" message on the packages of smokeless tobacco products.

Happy Hours—Will seek legislation to prohibit drinking establishments from offering inducements (such as "happy hours" and "two for one") to excessive alcoholic beverage consumption.

CME—Reaffirmed its position in support of mandatory continuing medical education (CME) for physicians.

Discipline—Supported adequate funding for the Medical Examining Board and offer the Board the assistance of the State Medical Society for consultation purposes in competence cases.

Home Health Care—Will seek the establishment of minimum criteria for home health care agencies in Wisconsin.

Nursing Homes—Requested state and federal governments to reevaluate rules and enforcement mechanisms for nursing homes to allow the more efficient delivery of medical care.

Health Care Bank—Directed SMS to study the Health Care Bank/IRA concept (a method of providing health care coverage by private savings) and submit a report on its advantages and disadvantages at next year's House of Delegates.

Nuclear Armaments—Proposed that the United States and Union of Soviet Socialist Republics reduce nuclear armaments; increase communication between their governments in respect to nuclear armaments, and formulate a more comprehensive, verifiable nuclear test ban treaty and an effective worldwide policy of nonproliferation of nuclear armaments.

Expert Witnesses—Referred to the SMS Medical Liability Committee a resolution calling for SMS to maintain the requirement for expert witnesses at panel hearings and that a joint SMS-Wisconsin Bar Assn committee establish criteria to qualify physicians as experts in order to testify in a particular field.

Countersuits—Directed the Society to consider introducing legislation which would remove the special injury element now required by Wisconsin law for a malicious prosecution countersuit and encourage physicians to make use of the current frivolous lawsuit statute.

Emergency Room Reimbursement—Referred to the SMS Board of Directors a resolution putting SMS on record as opposing any attempt to modify Wisconsin statute 146.301 which provides that no hospital may refuse emergency treatment to any sick or injured person. The resolution also directs staff to negotiate the adoption of the definition of "bona fide medical emergency" with DHSS and that the SMS Board assist in resolving the current conflict between emergency care providers and DHSS and HMOs as it regards payment for services rendered.

Second Opinions—Requested that the mandatory surgical second opinion data already collected by the Department of Health and Social Services be analyzed and made public to determine if true savings have resulted.

Decentralization of Health Care—Directed the SMS Board to consider a study on the cost of decentralization of health care in Wisconsin and report back to the House of Delegates.

HMOs—Supported, in principle, a resolution requesting that SMS promote physician input into HMO systems and consider the establishment of a unit within the Society for physicians to contact for advice and counsel regarding these new systems.

Monitoring of WiPRO—Rejected a resolution proposing a monitoring mechanism of WiPRO activities, but encouraged WiPRO to communicate more effectively with physicians.

WiPRO hearings—Rejected a resolution calling upon SMS to "exert its influence" to cause a return of the WiPRO reconsideration hearings to their previous on-site format.

1985 SMS Budget—Adopted the 1985 SMS Budget.

1986 Dues—Recommended that there be no change in SMS member dues for 1986.

Unified membership—Rejected a resolution calling for a return of unified membership in Wisconsin.

Section on Therapeutic Radiology—Created a specialty Section on Therapeutic Radiology. A delegate and alternate delegate to the House of Delegates will be elected by the SMS members of that group acting as a section of SMS.

Section on Gastroenterology—Rejected a resolution calling for the establishment of a specialty Section on Gastroenterology.

Safe transport of hazardous materials—Rejected a resolution directing SMS to seek legislation which would designate state departmental responsibility to assure hospital preparedness to safely treat radiologically contaminated patients in the event of a minor spent fuel accident. The resolution also asked that the Governor direct state officials to identify hospitals located along shipment routes and that the state train personnel in the use of the Radiation Accident Protocol, provide funds for equipping these hospitals, and periodically conduct emergency drills to assure continued preparedness.

Cost containment at AMA functions—Encouraged the AMA to continue to emphasize cost containment at all AMA functions.

A complete summary of all House actions appears elsewhere in this issue.■

Medical Museum season began May 1

When planning your summer vacation this year, don't forget to add the Fort Crawford Medical Museum in Prairie du Chien to your itinerary.

The museum, which opened for the 1985 season on May 1, is located at the reconstructed military hospital at Fort Crawford, a national historic landmark set in the Mississippi River Valley.

Visitors to the museum complex will see relics of nineteenth century medicine in Wisconsin, including displays depicting the Indian Medicine Man, the military fort physician, the family doctor from "horse and buggy" to present, great events in the development of surgery, replicas of physicians' offices of 1850 and 1900, and an old-time pharmacy.

This year will be a special one for the museum as it will celebrate the 200th anniversary of the birth of William Beaumont. Beaumont, a famous military surgeon, was stationed at Fort Crawford during the 1830s. The entire museum is a tribute to this surgeon, who while at the Fort, performed the now famous operations on the "man with the hole in his stomach," Alexis St Martin. These experiments formed the basis of our present day knowledge of the digestive system.

During the month of July, the museum will feature a special exhibit on Civil War photographs and lithographs. The special month on the Civil War will culminate with the Annual Civil War Encampment on July 27 and 28. On these days, the days of the Civil War are recreated when Civil War encampment groups from throughout the Midwest gather and set up historically accurate Union and Confederate camps on the museum grounds.

Also new this year is the Pomainville Reading Room in the museum's administration building. This facility, which will be open to the general public, is named in honor of Leland Pomainville, MD, a Wisconsin Rapids family physician who served as treasurer of the State Medical Society's Charitable, Educational and Scientific Foundation for nearly 18 years until his resignation in March 1985.

Another portion of the museum is dedicated to helping visitors learn more about the workings of the human body and how to stay healthy. One of the more popular exhibits there is the transparent twins, lifesize female models, one showing 25 organs of the body and the other the 200 bone skeleton and the nervous system. Their recorded messages describe the function of each organ and system which is illuminated individually as it is discussed.

The museum also has several "hands-on" exhibits, where visitors can learn how to control their future health. Physical fitness, the dangers of drunk driving, weight reduction, the birth of a baby, nutrition, alcohol and drugs, and immunization are all featured here.

For the art enthusiast, the museum's administration building has on display seven medical still-life paintings by internationally reknown artist Aaron Bohrod. Done in Bohrod's famous "trompe l' oeil" (fool the eye) style, the paintings depict various disciplines of medicine such as pediatrics, cardiology, infectious diseases, and neurology-psychology.

The Fort Crawford Medical Museum will be open this year from May 1 through October 31 from 10 am to 5 pm daily. Admission is $2.00 for adults, and 50 cents for children under 12.

Tour guides are avialable for groups with advance reservations. To make a reservation, call or write: Medical Museum, 717 Beaumont Road, Prairie du Chien, WI 53821. Phone: (608) 326-6960.■

FORT CRAWFORD MEDICAL MUSEUM
PRAIRIE DU CHIEN, WISCONSIN

Open daily May 1 through October 31
10 a.m. to 5 p.m.
Adults $2 Children $.50

Three building complex owned by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Summary report of SMS House of Delegates April 25–26, 1985, La Crosse, Wisconsin

THE HOUSE DELIBERATED 29 resolutions as well as reports of officers, the Board of Directors, commissions and committees, and the Task Force on Medical Care. Refer to the April 1985 Wisconsin Medical Journal for abstracts of resolutions 1 through 27 and their sources. Following is the text of the House of Delegates reference committee reports and indication of House action upon committee recommendations.

Reference Committee on National Issues

• **Report BB** of the **Committee on Federal Legislation** covers its attention to federal legislation affecting physicians and health care and is recommended for adoption.

Action: Adopted

• **Report J** of the **Committee on Environmental and Occupational Health** outlines its activities including the development of two resolutions (3 and 4) which will be dealt with separately; adoption of Report J recommended.

Action: Adopted

• **Report K** of the **Liaison Committee on Health Care Costs** discusses its efforts with business, labor, and others in cost containment; adoption recommended.

Action: Adopted

• **Report R** of the **Joint Practice Committee** indicates it is currently attempting to develop and prioritize specific objectives for its future; acceptance recommended.

Action: Accepted

• **Report S** of the **Physician/Nurse Liaison Committee** summarizes its activities including study of the future educational needs of nurses; adoption recommended.

Action: Adopted

• **Resolution 1** concerns the **Federal Nursing Home Code;** amended resolve proposed by the reference committee as follows:

RESOLVED, That the State Medical Society, American Medical Association, and other interested groups, request the state and federal governments to reevaluate rules and enforcement mechanisms for nursing homes to allow the more efficient delivery of medical care.

Action: Adopted as amended

• **Resolution 2** relates to **Health Care Banks/IRAs;** amended resolve recommended by reference committee as follows:

RESOLVED, That SMS study the Health Care Banks/IRA concept and work with advisors from the public and private sectors to determine logistical problems associated with it, and submit a report to the House of Delegates in 1986.

Action: Adopted as amended

• **Resolution 3** concerns **Reduction of Nuclear Armaments** and was introduced by the Committee on Environmental and Occupational Health; adoption recommended.

Action: Adopted

• **Resolution 4** on **Safe Transport of Hazardous Materials** introduced by the same committee was also recommended for adoption.

Action: Defeated after discussion by a vote of 79-33.

• **Resolution 5** concerns **Cost Containment at AMA Functions;** substitute resolve recommended by reference committee as follows:

RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin encourage the AMA to continue to emphasize cost containment at all AMA functions.

Action: Substitute adopted

Reference Committee on Organization and Finances

• **Report F, Commission on Public Information:** We take note of the "Doctor Al" TV series, compliment the Commission on the TV series and the

Healthwatch on medical professional liability, encourage dissemination of this information in the future, and recommend adoption of the report.

Action: Adopted

• **Report Q, Committee on Women Physicians:** We recommend this report be adopted and compliment the members of the committee on its vitality and their efforts to involve more women physicians in organized medicine.

Action: Adopted

• **Report T, Secretary Thayer:** We recommend this report be adopted and express our gratitude to Mr. Thayer for his efforts on behalf of the Society. Furthermore, we recommend the entire report that Mr Thayer gave to the House yesterday be adopted and wish to identify the physicians' review matter as an immediate priority for the Society and that this speech be published in the *Wisconsin Medical Journal.*

Action: Adopted

• **Report U, Board of Directors:** This was considered in four segments:

1. **Ad Hoc Committee on Nomination and Election Procedures:** We concur with the recommendation of the Ad Hoc Committee and the Board that the nomination and election process not be changed.

Action: Adopted

2. **Proposed 1985 Budget:** We note that this includes a $47,000 deficit but in light of what are considered to be adequate reserves, recommend the budget be adopted.

Action: Adopted

3. **1986 Dues:** In light of the current financial situation of many physicians, we concur with the conclusion reached in this part of the report and recommend there be no change in dues for 1986. However, at the same time we acknowledge future dues increases will be necessary, using the criteria established in prior years, to maintain adequate financial stability.

Action: Recommendation adopted

4. The balance of Report U was reviewed. We commend the Board for its diligent efforts and recommend adoption.

Action: Adopted

• **SMS Services, Inc. Informational Report:** SMSSI appears to be a good solid investment for the Society and members should take note of the many services provided.

Action: Report received

• **President Flaherty's Report:** We commend Doctor Flaherty for his leadership and his outstanding approach with the Task Force on Medical Care and for his advocacy as a spokesman for the Society.

Action: Report adopted

• **President-elect Scott's Report:** We thank Doctor Scott for his report and look forward to a very active year.

Action: Report adopted.

• **Treasurer Foley's Report:** We thank Doctor Foley and the Finance Committee of the Board for their diligent attention to the Society's financial matters.

Action: Report received [Financial statements printed in this issue]

• **Resolution 6** on **Unified Membership:** We heard testimony with the majority of it being against unified membership. As a result, we recommend that prior actions of the House of Delegates be reaffirmed that AMA membership be optional but recommended.

Action: Resolution not adopted

• **Resolution 7** on **Establishment of Section on Therapeutic Radiology** and **Resolution 8** on **Establishment of Section on Gastroenterology:** The reference committee recommended adoption of both.

Action: There was a request for division of the question which resulted in adoption of Resolution 7 and rejection of Resolution 8.

• As an additional consideration on this subject, it became apparent that the Society should have some specific **criteria for establishing Specialty Sections** in the future, and the reference committee reported a suggested amendment to Chapter XI, Section 1, of the Bylaws for informational purposes and with the understanding that it must be introduced in 1986 [and acted upon] in order to be effective at that time.

Action: Accepted as information

• Furthermore, we recommend the Board of Directors study the issue of **proportionate representation in the House of Delegates** based on Society

membership in each specialty section and report back to the House in 1986.

Action: Adopted

Reference Committee on Scientific Activities

• **Resolutions 9, 10 and 11** condemning **boxing** as a poorly regulated activity. The reference committee noted the inability to legislate safety for boxing participants and recommended the following substitute resolution be adopted:

RESOLVED, That the State Medical Society of Wisconsin educate the public concerning the dangerous aspects of boxing; and be it further

RESOLVED, That the Society through elected legislatures introduce legislation supporting the abolition of amateur and professional boxing in the state of Wisconsin.

Action: Substitute adopted

• **Resolution 12** is concerned with possible effects of **smokeless tobacco** and, if proven to be harmful, advocates support of an "injurious to health" message; adoption recommended.

Action: By motion from the floor, the reference committee report was amended to change the word "possible" to "demonstrated" and to strike the words "if proven to be harmful;" resolution and amendment adopted.

• **Resolution 13** is concerned with **inducements to alcohol consumption.** Because of testimony presented in open hearing which stated that "happy hours" encourage the abuse of alcohol in a short period of time, the committee recommended amendment of the resolution by inserting the words in parentheses:

RESOLVED, That the State Medical Society of Wisconsin encourage the Legislature to enact laws which would prohibit drinking establishments from offering inducements (such as "happy hours" and "two for one") to excessive alcoholic beverage consumption.

Action: Adopted as amended

• **Resolution 14** advocates continued support of **mandatory continuing medical education;** adoption recommended which reaffirms the position of the State Medical Society.

Action: Adopted

• **Resolution 15** recommends support of adequate **funding for the Medical Examining Board** and advocates an offer of **SMS consultation in incompetence cases** and a request of specialty societies for like cooperation; adoption recommended which reaffirms positions of the Society.

Action: Adopted

• **Resolution 16** seeks establishment of minimum criteria for home health care agencies in Wisconsin; adoption recommended.

Action: Adopted

• **Report A** of the **Commission on Continuing Medical Education** reports that the State Medical Society has been accredited through June 1990. The Commission has also dealt with preparation for the 1985 Annual Meeting; accreditation of hospitals and medical specialties within the state; development of a CME Source Book; approval of a program on treatment of hypertension, and recommendation of Herbert F Sandmire, MD, for the Erwin R Schmidt Interstate Postgraduate Teaching Award.

Action: Accepted

• **Report D** of the **Commission on Mediation and Peer Review** details its various activities in mediation, peer review, the Statewide Impaired Physician Program whose formal linkage with the Wisconsin Medical Examining Board through the Coordinating Council on Physical Impairment may be unique in the Nation; and the Medicaid Medical Audit Committee which is under contract to the State Department of Health and Social Services to perform evaluations and to assist in determining the acceptability or experimental status of new medical procedures. The reference committee lauds the work of the Commission and particularly commends the establishment of an ongoing liaison with government in which it acts as expert consultant.

Action: Accepted

• **Report G** of the **Wisconsin Medical Journal Editorial Board** sets forth objectives to: a) place more emphasis on information on current issues, b) increase coverage of specialty and county medical society activities, c) develop a Q and A feature to focus on day-to-day problems confronting physicians in their treatment of patients, and d) increase coverage of the Board of Directors, commissions and committees. The report also informs us of news media coverage of WMJ articles and a new front cover design.

Action: Accepted

• **Report H** of the **Committee on Aging and Extended Care Facilities** outlines concerns about nursing home reimbursement for intravenous therapy (at present not reimbursable by Medicare or Medicaid), planned review of the total nursing home reimbursement schedule, and medication errors in nursing homes. The Committee also reports discussions with the Coalition of Wisconsin Aging Groups on physicians' services for low income elderly, independent elderly living, implications of regulations, and experiences with HMO/PPOs and DRGs, and its current focus on various community options of health care for the elderly.

Action: Accepted with an amendment that the Board of Directors expand the scope of this committee to include home health care; further that the Board change the name to the **Committee on Aging, Extended Care Facilities and Home Health Care** and direct this committee to address in its 1986 report statewide home health care issues including quality and accessibility of home health care in our state as well as planned review of the total home care reimbursement schedule including reimbursement for home intraveneous therapy.

• **Report I** of the **Committee on Alcoholism and Other Drug Abuse** discusses review and input on State Department of Health and Social Services administrative rules concerning inpatient residential treatment facilities and patient rights, and DHSS proposals for legislative changes in mandated benefits. Among other activities, the Committee was concerned with cosponsorship with DHSS of a Citizens Conference on Alcoholism and Other Drug Abuse, investigation of a review course for addictionology credentialing, physician education, support for a National Cocaine Symposium, and cooperation with Alcoholics Anonymous.

Action: Accepted

• **Report L** of the **Committee on Maternal and Child Health** discusses activity in regard to the DES alert, consultation with the Physicians Alliance staff in analyzing causes of birth-related malpractice claims, Standards Development Project for perinatal care and, with the Maternal Child Health Coalition, review of the Healthy Birth Program and monitoring the MCH block grant. The Subcommittee on Maternal Mortality, in order to reduce maternal deaths through study of changing patterns and dissemination of information to health care providers, seeks increased information through the Bureau of Vital Statistics and has developed improved data survey sheets.

Action: Accepted

• **Report M** of the **Committee on Medicine and Religion** reports continued distribution of the booklet, "The Ethics of Less Care," and cosponsorship with the Catholic Physicians Guild of the annual Medicine and Religion Breakfast with a talk on "Native American View of Medicine and Religion."

Action: Accepted

• **Report O** of the **Committee on Safe Transportation** expresses continued concern for blood alcohol levels considered legal and/or safe for driving and recommends that a positive publicity campaign be conducted reiterating the Society's positions. As Medical Advisory Board to the State DOT, the Committee reaffirmed Society opposition to use of telescopic spectacles for driving, and reviewed the heart disease reporting form used by physicians and medical standards for school bus operation. The Committee continues to seek clarification of confidentiality of BAC tests through legislation, and commended Frederick Bunkfeldt, MD, on 21 years of service to the Committee.

Action: Accepted

• **Report P** of the **Committee on School Health** details testimony at Department of Public Instruction and legislative hearings in support of comprehensive school health education, work with the Wisconsin Coalition for School Health Education in development of a resource directory and a research document on health problems of Wisconsin school children, and executed and planned public service announcements on responsible alcohol use. The Committee also monitored progress on development of a curriculum guide which includes time allocations for health education, reviewed medical forms used by the Wisconsin Conservation Corps, reviewed boxing rules, and introduced resolution 11 to the House of Delegates urging elimination of boxing.

Action: Accepted

Reference Committee on Socioeconomic Activities

• **Report B** of the **Commission on Governmental Affairs** outlines legislative issues considered by it during the past year. The 1985 Special Annual Meeting Edition of **Capitol Week** supplements this report (indicating SMS positions on items in the Budget Bill, changes in the "Living Will" law, interest on insurance claims, PT practice without referral, seat belts, hospital privileges for oral and maxillofacial surgeons) and other anticipated legislation. We recommend adoption of Report B and the CAPITOL WEEK supplement and commend Doctor J D Kabler for his nine years of dedicated leadership.

Action: Adopted

• **Report C** of the **Commission on Health Planning** describes its major issues. Under the direction of the Commission, the **Health Manpower Task Force**, created by the 1984 House of Delegates, prepared a report with recommendations on physician supply in Wisconsin. The reference committee commends the Commission and its Health Manpower Task Force for its monumental study, and recommends adoption.

Action: Adopted

• **Report E** of the **Physicians Alliance Commission** and **Medical Liability Committee** outlines the major policy initiatives undertaken (medical liability, alternative delivery systems, physician contracting, reimbursement issues, Medicare assignment, WMAP, peer review, joint ventures). The MLC report summarizes the 19-point plan developed for liability reform. The reference committee commends Doctor Kenneth M Viste, Jr, for his able direction of the activities of the Physicians Alliance Commission, and recommends adoption.

Action: Adopted

• **Report N** of the **Committee on Mental Health** describes activities which were directed at the resolution of problems associated with the delivery of mental health services. The reference committee commends Doctor Pauline Jackson for her diligent and devoted service and recommends adoption.

Action: Adopted

• **Resolution 17** recommends that the State Medical Society continue its efforts to maintain the requirements for **expert witnesses at panel hearings** and that a joint SMS-State Bar committee establish criteria to qualify physicians as experts for purposes of testimony in a particular field. The committee supports the resolution in principle and recommends that it be referred to the Medical Liability Committee for further study.

Action: Referred

• **Resolutions 18 and 19,** both dealing with **special injury element of countersuits,** were considered together. Your reference committee recommends a substitute resolve as follows:

RESOLVED, That the Society consider introducing legislation which would remove the special injury element now required by Wisconsin law for a malicious prosecution countersuit and encourage physicians to make use of the current frivolous lawsuit statute.

Action: Substitute adopted

• **Resolution 20** deals with an **international scope study on professional liability.** The reference committee recommends an amended resolve as follows:

RESOLVED, That the State Medical Society of Wisconsin ask the AMA to undertake a study on how the liability situation is handled on an international scope to include, but not be limited to, English speaking countries.

Action: Adopted as amended

• **Resolution 21** dealing with the **appeal and monitoring mechanism** for patients and their physicians is recommended for adoption, recognizing that the Board of Directors of the Society has already directed that the Physicians Alliance Commission undertake a program to serve as a focal point for the reporting and monitoring of incidents involving DRGs, HMOs, third parties, and governmental regulations which adversely affect the ability to provide proper care for patients.

Action: Adopted

• **Resolution 22** deals with the **emergency department reimbursement for treatment of HMO/AFDC patients.** The reference committee recognizes the problems addressed in this resolution, but because of the complexities involved recommends that it be referred to the Board of Directors for further study.

Action: Referred with third resolve amended to read "That the SMS Board of Directors assist in resolving the current conflict between emergency care providers and the DHSS and HMOs as it regards payment for services rendered."

• **Resolution 23** recommends that the **certificate of need/capital expenditure review law be repealed.** The reference committee recommends approval, recognizing that the SMS Task Force on Medical Care is also recommending repeal of the CON/CER law.

Action: Adopted

• **Resolution 24** recommends that the Society urge the Secretary of the DHSS to fund a study on **mandatory surgical second opinion.** Your reference committee recommends a substitute resolve as follows:

RESOLVED, That the mandatory surgical second opinion data already collected by the Department of Health and Social Services be analyzed and made public to determine if true savings have resulted.

Action: Substitute adopted

• **Resolution 25** recommends a study on the **cost of decentralization of heathcare** in Wisconsin. The reference committee recommends an amended resolve as follows:

RESOLVED, That the Board of SMS consider a study on the cost of decentralization of healthcare in Wisconsin and report back to the House of Delegates.

Action: Adopted as amended

House of Delegates 1985–86 Nominating Committee

(Elected by House April 25, 1985)

DISTRICT		
1	Jerome W Fons, Jr, MD	Cudahy
1	Robert F Purtell, Jr, MD	Milwaukee
1	John D Riesch, MD	Menomonee Falls
1	Raymond E Skupniewicz, MD	Racine
2	Sandra Osborn, MD	Madison
2	James J Tydrich, MD	Richland Center
3	Stephen B Webster, MD	La Crosse
4	John E Thompson, MD	Nekoosa
5	Kenneth M Viste, Jr, MD	Oshkosh
6	Robert T Schmidt, Jr, MD	Green Bay
7	Merne W Asplund, MD	Bloomer
8	Joseph M Jauquet, MD	Ashland
SPECIALTY SECTIONS	Philip J Dougherty, MD	Menomonee Falls

Attendance: 1064

Total attendance of the two-day scientific program April 26-27, 1985 at the La Crosse Center was 1064.

Registration of physician members was 728, 22 nonmember physician registrants, and 44 guest physicians, while the balance consisted of 129 technical exhibitors; 32 scientific exhibitors; 45 interns, residents, and medical students; and 64 guests (certified nurses, physician spouses, and others).

The three sessions of the House of Delegates had the following registrations: 121 first session; 128 second session; and 127 third session. There are 167 voting members of the House. House sessions were held April 26-27, 1985.

Credentials Committee

Glenn M Seager, MD, La Crosse, *Chairman*
Emma K Ledbetter, MD, La Crosse
Jeffrey M Weber, MD, Milwaukee

THANK YOU

The reference committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done."

Organization and Finances

William E Raduege, MD, Woodruff, *Chairman*
Charles E Pechous Jr, MD, Kenosha
Robert B Shapiro, MD, Madison
James L Basiliere, MD, Oshkosh
Richard G Roberts, MD, Darlington

Socioeconomic Activities

Norman J Schroeder II, MD, Beaver Dam, *Chairman*
Lucille B Glicklich, MD, Milwaukee
John A De Giovanni, MD, Prairie du Sac
Philip J Dougherty, MD, Menomonee Falls
John O Simestad, MD, Osceola

Scientific Activities

Raymond E Skupniewicz, MD, Racine, *Chairman*
Robert A Keller, MD, Sheboygan
Leon J Radant, MD, Mauston
Myron M Marlett, MD, Green Bay
Roland R Liebenow, MD, Lake Mills

National Issues

Dean D Miller, MD, Milwaukee, *Chairman*
John E Riesch, MD, Menomonee Falls
Kermit L Newcomer, MD, La Crosse
Jeffrey K Polzin, MD, Black River Falls
Edward A Burg Jr, MD, Milwaukee

Credentials

Glenn M Seager, MD, La Crosse, *Chairman*
Emma K Ledbetter, MD, La Crosse
Jeffrey M Weber, MD, Milwaukee

Duane W Taebel, MD
Speaker

• **Resolution 26** requests that SMS promote **physician input into HMO systems** and consider the establishment of a unit within the Society for physicians to contact for advice and counsel regarding these new systems. The reference committee supports this resolution in principle and recommends adoption recognizing that the SMS Task Force on Medical Care has made a similar recommendation.

Action: Adopted

• **Resolution 27** proposes a **monitoring** mechanism **of WiPRO activities.** The reference committee recommends rejection, but encourages WiPRO to communicate more effectively with physicians.

Action: Resolution rejected

• **Resolution 28** (Director Hofbauer) deals with **WiPRO reconsideration hearings.** The reference committee recommends rejection on the basis that it would not be a good use of financial resources to return to on-site hearings and that telephone conferences appear to be a workable alternative.

Action: Resolution rejected

• **Resolution 29** (Director Wood) addresses **health-care cost containment savings.** The reference committee recommends adoption of a substitute resolve as follows:

RESOLVED, That the State Medical Society implore all insurance companies to pass the results of cost containment on to the citizens of Wisconsin in the form of lower premiums.

Action: Substitute adopted, changing the word "implore" to "request"

• **Other Actions**

• **Task Force on Medical Care**

At the first session members of the House received an Executive Summary and Task Force Report VII, as well as the reports of five work groups and a report entitled "General Economic Conditions Facing Physicians in Wisconsin." A special hearing was conducted Friday morning, April 26, by Task Force Chairman Flaherty and the work group chairmen. At the second House session Friday afternoon, President Flaherty reported the recommendation that the Task Force study in its entirety be referred to the Board of Directors for further action and direction, with probable referral back to the House for specific policy issues. This was adopted by the House.

- Elected a Nominating Committee whose membership is published in this issue.

- Elected officers, AMA delegates and alternates, and confirmed the elections of district directors, also reported in this issue.■

Doctor Flaherty turns over the presidency to Doctor Scott

THE FOLLOWING FINANCIAL STATEMENTS of the State Medical Society of Wisconsin are part of the Treasurer's Report to the House of Delegates. The Annual Certified Audit, prepared by Bailey, Calmes & Co, certified public accountants, is on file at Society headquarters. Members wishing to review the Audit may do so upon inquiry to the Secretary.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

General Fund
BALANCE SHEET
December 31, 1984

ASSETS

Current Assets		
Cash		($ 48,768.33)
Accounts Receivable—General (Net of Doubtful Accounts)		36,662.73
Due from Affiliated Organizations		48,960.01
Due from Other Organizations for Accrued Payroll and Vacation Pay		24,308.02
Commercial Paper		500,000.00
U.S. Government and Other Securities		1,223,912.32
Certificates of Deposit		500,000.00
Repurchase Agreement		70,000.00
Common Stock—At Cost (Market Value $91,773.00)		89,480.28
Cash Management Fund		151,000.00
Accrued Investment Income Receivable		45,332.01
Employee Travel Advances		1,500.00
Prepaid Expenses		19,437.33
Supplies Inventory		14,291.63
Total Current Assets		$2,676,116.00
Fixed Assets		
Real Estate—Office Building	$1,093,595.12	
Real Estate—Storage Building	113,386.25	
Other Real Estate	91,792.59	
Building Equipment	58,547.70	
Furniture and Equipment	289,800.10	
Data Processing Software	29,386.50	
Subtotal	$1,676,508.26	
Less: Accumulated Depreciation	1,027,594.11	
Net Book Value		648,914.15
Less: Leasehold Improvements Paid by Other Organizations	40,781.25	
Net Fixed Assets		608,132.90
Other Assets		
Investment in SMS Services, Inc.	$146,521.40	
Total Other Assets		146,521.40
TOTAL ASSETS		$3,430,770.30

LIABILITIES

Current Liabilities		
Accounts Payable	$ 37,752.36	
Dues Held for the Section on Ophthalmology	428.81	
Dues Payable to American Medical Association, County Medical Societies and Other Organizations	123.67	
Accrued Payroll Taxes and Other Payroll Deductions	3,857.12	
Accrued Property Taxes Payable	55,837.75	
Accrued Sales Tax Payable	295.74	
Accrued Income Tax Payable	1,840.00	
Accrued Payroll and Vacation Pay	94,112.00	
Accrued Health Incentive Plan	25,991.72	
Accrued Retirement Plan Contributions Payable	18,975.85	
Other Current Liabilities	600.00	
Deferred Income:		
Prepaid 1985 Annual Meeting Income	$ 11,750.00	
Prepaid 1985 Membership Dues	1,493,192.38	
Prepaid Rental Income	4,018.77	1,508,961.15
Total Current Liabilities		$1,748,776.17

SURPLUS

Balance, January 1, 1984		$1,510,083.95
*Excess Income Over Expense for the Year Ended December 31, 1984 (SMS Only)		127,556.06
Subtotal		$1,637,640.01
Plus: Increase in Value of Investment in SMS Services, Inc.		44,354.12
Balance December 31, 1984		1,681,994.13
TOTAL LIABILITIES AND SURPLUS		$3,430,770.30

*Legal Reserve	$ 20,116.00	
Regular Operations	107,440.06	
	$127,556.06	

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

General Fund
STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1984

INCOME

Membership Dues		$1,905,858.95
Income From Invested Funds(1)		194,233.87
Annual Meeting Income		38,213.00
AMA Collection Fees		17,202.13
Wisconsin Medical Journal Advertising, Subscriptions, and Reprint Income		81,433.80
Mailing Labels		7,658.15
Equipment and Building Rental		147,303.26
Contract Services Furnished Other Organizations		20,573.43
Duplicator, Cafeteria & Telephone Recovered From Other Organizations		40,001.04
Other Income		4,982.26
TOTAL INCOME		$2,457,459.89

EXPENSES

Payroll	$1,021,722.35	
Payroll Related Costs	266,595.82	
Travel Expenses	146,468.65	
Telephone Expense	60,262.47	
Conference Expense	86,504.31	
Postage	65,900.47	
Outside Services	52,591.77	
Printing and Supplies	214,693.21	
General Insurance	14,677.52	
Association Dues	5,033.20	
Resource Materials	6,474.78	
Grants and Appropriations	13,765.00	
Rent	1,827.00	
Property Taxes	55,837.75	
Repairs and Maintenance	21,621.61	
Mail Service	32,021.61	
Computer Rent	35,600.00	
Depreciation	65,613.17	
Speakers Expense	10,000.47	
Legal Counsel	36,062.65	
Certified Public Account Services	17,449.15	
Actuarial Expense	15,948.00	
Miscellaneous Expense	7,752.61	
Provision for Bad Debts	1,575.00	
Utilities	61,270.80	
Building Supplies	10,794.22	
1984 Income Tax on WMJ Advertising Income	1,840.24	
TOTAL OPERATING EXPENSE		$2,329,903.83
EXCESS INCOME OVER EXPENSE		$ 127,556.06

NOTE:
(1) Income from Invested Funds includes a $10,000.00 dividend received by the State Medical Society from SMS Services, Inc. during 1984.

Chairman of the Board of Directors, Darold A Treffert, MD at left presenting the Directors Award to Edward J Lennon, MD, and above to Arnold L Brown, MD.

Medical School deans receive Directors Award

The deans of the two Wisconsin medical schools were presented the Directors Award of the State Medical Society during its Annual Meeting in La Crosse.

Arnold L Brown, MD, dean of the University of Wisconsin Medical School, Madison, and Edward J Lennon, MD, dean of the Medical College of Wisconsin, Milwaukee, were the 49th and 50th recipients of the award which is granted only on occasion to those "who have served with outstanding distinction the science of medicine, their fellow physicians, and the public."

Excerpts from the award follow:

Arnold L Brown, MD:

For 25 years, Arnold "Bud" Brown has built a career of medical education. His dedication to this essential element of American Medicine is applauded by colleagues, appreciated by students, and praised by patients. In seeking to create "the complete physician" from the raw material of each student, he draws from the wellspring of intelligence, compassion and commitment that so obviously shapes his own life.

Doctor Brown, a native of Wooster, Ohio, is a 1949 graduate of the Medical College of Virginia. In 1959 he joined the faculty of the Mayo Clinic Graduate School of Medicine in Rochester, Minnesota. He was chairman of the Department of Pathology and Anatomy at the Clinic and its medical school when he left in 1978 to assume the post of dean of the UW Medical School in Madison.

He arrived when good times seemed on the horizon. . .enrollment was increasing, and a new hospital and teaching facilities were nearly completed. However, medical education was about to enter a new era, an era of shrinking resources for medical education. Yet in the face of this uncertain societal commitment to medical education, Doctor Brown has proved himself to be more than equal to the challenge. Under his quiet, confident leadership, the UW Medical School has maintained its reputation for excellence in education, research and patient care.

Through his involvement in state and county medical society activities he has demonstrated the benefits of bridging the gap between "town and gown."

Over the years, he has earned a national reputation for his work in cancer and he has served on several national medical councils dealing with heart disease, cancer and stroke.

The future of medical care in Wisconsin and the nation rests heavily in the hands of the deeply dedicated and highly sensitive teacher, clinician, administrator who in this combination of skills is known as medical educator. . .few so well exemplify these characteristics of excellence as our own Arnold L Brown.

Edward J Lennon, MD

For more than two decades, Edward J Lennon, MD, has displayed a commitment to medicine and medical education that is admired by colleagues, students, and patients alike. Be it clinician, teacher, or administrator, he has approached each of these roles with the same qualities of intelligence, compassion, and determination that he looks for in his medical students.

A native of Chicago, Illinois, Doctor Lennon graduated from Northwestern University School of Medicine in 1952.

Doctor Lennon began his association with the Medical College of Wisconsin in 1958 when he joined the faculty as an instructor in medicine. He was named assistant professor in 1961, associate professor in 1966, and professor in 1968.

Since that time, he has become increasingly involved in administration. In 1978 Doctor Lennon was named Dean and Academic Vice President of the Medical College of Wisconsin and in May 1984 he be-

continued

Outstanding medical students receive Houghton Award

The Houghton Award of the State Medical Society's Charitable, Educational and Scientific Foundation is given yearly to senior medical students who "through scholastic excellence, extracurricular achievement, and interest in medical organization show high promise of becoming a complete physician.

This year's recipients are Thomas Stauss of the University of Wisconsin Medical School and Nell Davis of the Medical College of Wisconsin.

The award, consisting of a check for $250 and a plaque, was presented to Mr Stauss and Ms Davis April 25 during the SMS Annual Meeting.

Majoring in zoology, Thomas Stauss received his Bachelor of Science degree from the University of Wisconsin-Madison. While an undergraduate, Stauss was an accomplished athlete, having played football for the Wisconsin Badgers for four years. In 1977, 1978 and 1979 he was named to All Big 10 Academic First Team. In 1979, his senior year, he was also nominated for Big 10 Most Valuable Player. That same year, he received the Ivy Williamson Award for Outstanding Achievement in Athletics and Academics.

In 1980 he entered the University of Wisconsin Medical School where his outstanding scholastic performance continued. In his junior year, Stauss was selected to the national medical honor society Alpha Omega Alpha.

Stauss is married and has two children.

A native of Appleton, Wisconsin, Nell Davis received her Bachelor of Science degree from Beloit College in 1978. After working in research at the University of Massachusetts Medical Center and then at the Enzyme Institute of the University of Wisconsin, she entered the Medical College of Wisconsin in 1981.

While in medical school, Ms Davis was active in the local chapter of the American Medical Student Association (AMSA); and during the summer of 1983, she was a participant in the AMSA Health Study Tour of Pakistan. During the past two years, she has been a member of the Medical College of Wisconsin's Student Affairs Committee and in 1983-84 she served as its chairman.

Besides medicine, Ms Davis is interested in music. She plays trumpet and sings in several choirs.

The Houghton Award was established in 1968 by the late John H Houghton, a Wisconsin Dells general practitioner, to emphasize the high ideals for future physicians. Later, his brother, William J Houghton, a Milwaukee surgeon, added to the fund.■

DIRECTORS AWARD *continued*

came the fourth President of the College.

Described by friends and associates as bright, articulate, savvy, and compassionate, with a healthy sense of humor, Doctor Lennon has made significant contributions over the years in advancing the College's programs, education, research, and patient care to national prominence.

A man with a keen interest in science and research, as well as the socioeconomic aspects of medicine, Doctor Lennon has been an articulate spokesperson for the profession and has offered creative ideas regarding moderating healthcare costs, organizing regional hospital systems, and stressing the importance of quality biomedical research by medical school faculty.

Doctor Lennon's leadership in medical education has not been limited to Wisconsin. He served as the first chairman of the Council of Deans of Private Freestanding Medical Schools, from 1979 to 1983, an organization he helped establish to study management and academic programs at thirteen US medical schools.

An active participant in organized medicine, Doctor Lennon has sought to improve communication between academic and office-based physicians through his work on the Liaison Committee between the Medical College of Wisconsin and the Medical Society of Milwaukee County.

If the future of medical care is largely determined by the quality of the men and women we train today in our medical schools, what better role model would we give them but Edward J Lennon?■

Robert T Cooney, MD, president of the CES Foundation, at left below with Houghton Award recipients Nell Davis and Thomas Stauss

Corporation recognized for support of primary care

The Wisconsin Rural Rehabilitation Corporation (WRRC) of Madison received a Special Recognition Award from the State Medical Society of Wisconsin April 25 at the Annual Meeting in La Crosse.

Receiving the award on behalf of Wisconsin Rural Rehabilitation Corporation was Mr Francis Powers, WRRC secretary-treasurer. The special recognition award was given to the corporation "for its unique and continuing support to primary medical care as a keystone to improvement of the quality of rural life in Wisconsin."

According to SMS President Timothy Flaherty, MD, who made the award presentation, "the Wisconsin Rural Rehabilitation Corporation for many years has been instrumental in the advancement and promotion of quality medical care for residents of rural Wisconsin through its support of educational scholarship programs for medical students and residents."

For fourteen years, the corporation has provided the chief financial support for a Summer Externship Program operated jointly by the State Medical Society's Charitable, Educational and Scientific Foundation and the Wisconsin Academy of Family Physicians. This program, which was begun in 1969, has each year afforded some 30 freshman medical students an opportunity to spend eight weeks living and working with family physicians throughout Wisconsin during the summer.

"This summer externship is uniquely directed toward helping to relieve physician shortages in rural Wisconsin as well as improve the level of health care in these communities," says Doctor Flaherty. "Several of these students have finished their undergraduate training, gone on to family practice residency programs, and now practice as family physicians in rural Wisconsin and in communities where there is a major need for family doctors."

Just last year the administration of the program was assumed solely by the newly created Institute of Family Medicine and continues with major support from the Wisconsin Rural Rehabilitation Corporation. Since its first involvement in 1971, the WRRC has contributed more than $300,000 to support well over 500 students in this learning experience.

In addition, since 1973 the corporation has given more than

Interstate Teaching Award goes to Doctor Sandmire

Herbert F Sandmire, MD, a Green Bay obstetrician-gynecologist, was honored with the Erwin R Schmidt Award of the Interstate Postgraduate Medical Association of North America, April 25, during the State Medical Society's Annual Meeting in La Crosse.

Doctor Sandmire received the award in recognition of "his outstanding qualities as a teacher of medical students, to prepare them for both the art of medicine, and in skills of diagnosis and treatment of the ill and troubled," according to the Association.

Doctor Sandmire has been a preceptor for senior medical students from the University of Wisconsin Medical School for 20 years and during this time approximately 150 students have passed under his tutelage. In addition, over the past five years he has housed and fed the students in his home; thus providing exposure to the home life of a private practicing physician.

In presenting the award to Doctor Sandmire, Interstate Trustee John E Dettmann, MD, Green Bay, said, "his scientific and service contributions to the community and his county and state medical societies have provided an exemplary role model for the students." He also noted that Doctor Sandmire has also published several studies from his practice.

The University of Wisconsin Medical School has called him "one of the best preceptors the program has had since its inception in 1926."

Since 1966, the Erwin R Schmidt Interstate Teaching Award has been presented to a physician who has served the profession with distinction as a practicing physician and teacher. It is named in honor of Doctor Erwin R Schmidt, a former trustee of Interstate, who for many years was chairman of the Department of Surgery at the University of Wisconsin Medical School. ■

Doctor Sandmire (in background) and Doctor Dettmann

Doctor Flaherty and Mr Francis Powers

SPECIAL RECOGNITION AWARD *continued*

$340,000 in support to a Resident Family Physician Program of the University of Wisconsin—Madison Center for Health Sciences. This program enables residents in family medicine to practice at rural clinic sites for one to two months. The corporation also contributed some $240,000 each year to scholarships of other types including grants to students pursuing medical and other health careers.

"Few organizations have acted so generously to ensure the continuation of quality medical and health services for rural Wisconsin," according to Doctor Flaherty.■

Maryland physician recipient of Beaumont Award

"Seeing the Elephant: Medical Problems on the Oregon-California Trail" was the title of the presentation made by Peter D Olch, MD April 27 at the 1985 William Beaumont Memorial Lecture. Doctor Olch is an associate professor of Uniformed Services University of the Health Sciences, School of Medicine.

Established by the State Medical Society of Wisconsin in 1957, the William Beaumont Memorial Lecture is designed to present to members of the Society, distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners.

The lecture is given each year during the surgery meeting of the State Medical Society's Annual Meeting. Doctor Olch received the Beaumont Award from Stephen B Webster, MD of La Crosse, vice president of the Charitable, Educational and Scientific Foundation which administers the Beaumont Award Fund.■

Doctor Mullooly and Jenifer Jowsey, DPhil

Doctor Jowsey delivers Elvehjem Lecture

Jenifer Jowsey, DPhil, Healdsburg, CA presented the 1985 Elvehjem Memorial Lecture April 27 during the Internal Medicine program at the SMS Annual Meeting at the La Crosse Center. Doctor Jowsey spoke on "The Morphology and Treatment of Osteoporosis."

The Elvehjem Memorial Lecture was established in 1962 to honor the memory of Conrad A Elvehjem, PhD, the 13th president of the University of Wisconsin and an international authority in biochemistry. A project of the State Medical Society's Charitable, Educational and Scientific Foundation, the lecture is designed to perpetuate Doctor Elvehjem's contribution to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians. Doctor Jowsey was presented the Elvehjem Award by John P Mullooly, MD, at the Spring Meeting of the Wisconsin Society of Internal Medicine and the American College of Physicians.■

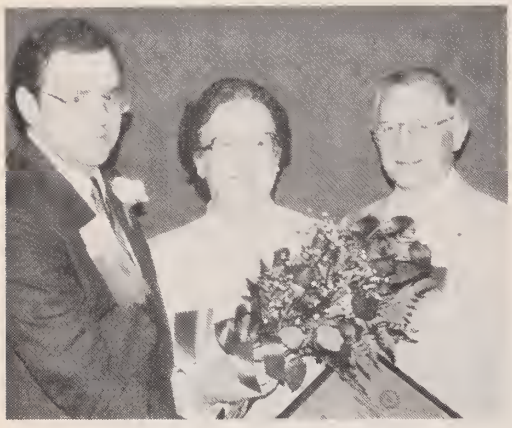
Doctor Webster and Doctor Olch, recipient of the Beaumont Award

Society honors long-time employee

One of the State Medical Society's most loyal and conscientious employees, Joan Pyre, was honored with the Presidential Citation of the State Medical Society April 25 in La Crosse.

In presenting the award to Miss Pyre, SMS President Timothy T Flaherty, MD, said:

"Joan is highly dedicated to her work, to high ideals, and to the medical profession. In this era where attacking professionalism is fashionable. . .the Citation allows us as physicians to show our appreciation to this woman of our staff—a selfless person, gracious, highly knowledgeable, especially skilled in helping others, a dedicated Executive Assistant to the Medical Society, its officers and staff and the public they serve."



President Doctor Flaherty, Presidential Citation recipient Joan Pyre, and Society Secretary Earl R Thayer

Joan Pyre began her first full-time employment in Madison in 1943 just out of advanced secretarial training at Edgewood College. She was secretary to the Superintendent of the Milwaukee Railroad at the depot offices on West Washington Avenue.

After four years of "railroading" Joan returned to the University of Wisconsin for a Bachelors of Business Administration degree from the School of Commerce.

Joan began her first day of work with the State Medical Society on February 6, 1951 as secretary to Roy T Ragatz, the Society's Assistant Secretary in charge of scientific programming. After a year with Roy, Joan was named Council and Committee Secretary for the Society and Assistant to then Secretary Charles H Crownhart. Her job was particularly challenging, said Doctor Flaherty, because, at that time, the Secretary of the Society was also the General Manager of Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society. "Those were turbulent years. Joan had a ringside seat to the intense, sometimes bitter, competition between the Blue Plans in Wisconsin. She was combined recorder, technical advisor, and "woman in the middle" confidant for medical society leadership frequently in contention and seldom in unanimity, but often innovative in the burgeoning era of medical and hospital insurance in Wisconsin."

Those experiences, combined with an almost unique natural talent for detail, have won her widespread admiration as "Miss Memory," according to Doctor Flaherty. "Few can challenge her rare skill at recollection, even fewer have refined this quality to an art in which utility and enjoyment are so satisfactorily combined."

With the retirement of Mr Crownhart in 1970, Joan helped smooth the transition to the Society's next Secretary and General Manager, Earl Thayer. Shortly, she was named Executive Assistant. A bit later she was appointed Secretary to the Wisconsin Delegation to the American Medical Association.

The announcement of that appointment said, "Few, if any in the Society, have a better knowledge of the system, the Society's policies and programs, or the technical aspects of the SMS and AMA procedures and protocol."

Outside the office Joan is well known for her fine alto voice in the Diocesan Festival Choir of Madison. This elite choral group has several times toured Europe; and with Joan in a quartet is a popular addition to the Madison area music scene.

"Certainly we in Wisconsin Medicine are fortunate that Joan continues as she started nearly 35 years ago—working on the railroad, all the live long day, every working day and then some," said Doctor Flaherty.■

Scientific Exhibit Awards

The following scientific awards were given special merit during the 1985 Annual Meeting of the State Medical Society of Wisconsin:

FIRST PLACE: ***Prevalance of Hearing Impairment in a Physical Rehabilitation Hospital*** by Sacred Heart Rehabilitation Hospital, Milwaukee.

SECOND PLACE: ***Laboratory Identification of Thrombotic Risk*** by Columbia Hospital, Milwaukee, and ***Comparison of Minoxidil with Hydralazine as Step III Drug in Hypertension*** by Wood Veterans Administration Medical Center, Medical College of Wisconsin, and the Upjohn Company.

THIRD PLACE: ***Prevention, Diagnosis, Treatment and Rehabilitation of Heart Disease*** by Wisconsin Heart Institute and Gundersen Clinic Ltd, La Crosse, and ***Autologous Blood Transfusion*** by American Association of Blood Banks Committee on Autologous Transfusion and St Mary's Hospital Blood Transfusion Service, Milwaukee.■

CES Foundation treasurer Richard W Edwards, MD with "Beaumont 500" Club members Karver L Puestow, MD and Leonard B Torkelson, MD and Mrs Torkelson

The "Beaumont 500" Club

One of the most unique, educational and cultural institutions in the Midwest if not the nation, is the Fort Crawford Medical Museum. It is far more than a museum, it is a tribute to all Wisconsin physicians and their role in securing the good health of the people of the State of Wisconsin. It represents a unique concept in the public education for prevention and treatment of injury and disease, the nature of medical care, the importance of the strong physician-patient relationship, and emphasis on obtaining and keeping good health.

The restored Fort Crawford military hospital, and its related museum in Prairie du Chien, is a tribute to Dr William Beaumont; it is also a modern expression of his 1830s philosophy of the search for truth and improvement in health. The museum has had more than 40,000 visitors since 1979, making it one of the most popular attractions in the area. Yet the museum continues to face financial hardships as well as some physical problems.

To this end, the MMP Endowment Fund was established in late 1981. This Fund has a goal of raising at least $500,000, the corpus of which cannot be used for any purpose other than to produce income earmarked for operation and maintenance of this unique National Historic Landmark.

The first 500 physicians or others who contribute $1,000 or more to the Museum Endowment Fund will join a select group known as the "Beaumont 500." Such contributors will receive a specially designed Beaumont Medallion. In addition to being a member of the prestigious "Beaumont 500," those who contribute $10,000 or more will receive a first edition copy of Dr William Beaumont's famous book *Experiments and Observations on the Gastric Juice and Physiology of Digestion,* written while Doctor Beaumont was stationed in Prairie du Chien, 1829-1832, and published in 1833.

To date, 31 individuals have committed $1,000 each to the Museum Endowment Fund. Through the continued generosity of Wisconsin physicians and their spouses, the Fort Crawford Medical Museum can continue to familiarize our citizens—young and old—with the fascinating people and events that have helped shape Wisconsin Medicine.

It gives the CES Foundation great pleasure to be able to thank the following for their continued support:

Mr and Mrs Robert B Murphy, Madison
Guy W Carlson, MD, Madison
W Bruce Fye, MD, Marshfield
Pauline M Jackson, MD, LaCrosse
Dr and Mrs William D Janssen, Mequon
Dr and Mrs Thomas A Leonard, Madison
Karver L Puestow, MD, Madison
John D Riesch, MD Menomonee Falls
Anonymous
Marion Crownhart, Madison
Eli M Dessloch, MD, Prairie du Chien
Melvin F Huth, MD, Baraboo
Michael F Ries, MD, Brownsville
Elizabeth A Steffen, MD, Racine
Kenneth M Viste, Jr, MD, Oshkosh
W Bradford Martin, MD, Whitehall
Mr and Mrs Earl R Thayer, Madison
Dr and Mrs K Alan Stormo, Fond du Lac
Dr and Mrs Chesley P Erwin, Milwaukee
Dr and Mrs Leonard B Torkelson, Baldwin
Leland C Pomainville, MD, Wisconsin Rapids
Mrs William D Hoard, Fort Atkinson
Dr and Mrs Ralph Hudson, Eau Claire
Roger L von Heimburg, MD, Green Bay
Dr and Mrs Richard W Edwards, Richland Center
Roy Selby, MD, LaCrosse
Dr and Mrs Bertram H Dessel, Wauwatosa
Mace Garrison Zinggeler, Venice, Florida
Dr and Mrs Benjamin H Brunkow, Monroe
Dr Robert T Cooney, Portage■

New Fifty-Year Club members

Physicians inducted into the Fifty-Year Club were presented awards at the Board of Directors dinner April 24 during the Annual Meeting of the State Medical Society. Those attending are shown above. Front row, left to right: Arthur D Bussey, MD, Wauwatosa; Kenneth F Manz, MD, Neillsville; Albert H Stahmer, MD, Wausau; Thorolf F Gundersen, MD, La Crosse; Kermit W Covell, MD, Racine. Back row, left to right: Hobart H Wright, MD, Wauwatosa; Stephen A Theisen, MD, Fond du Lac; Frederick J Hofmeister, MD, Milwaukee; Thomas J Doyle, MD, Superior; and Christopher R Dix, MD, Elm Grove.

Others who became members this year are: Clement L Budny, MD, Milwaukee; Garrett A Cooper, MD, Madison; Howard L Correll, MD, Arena; Frank K Dean, MD, Madison; Eli M Dessloch, MD, Prairie du Chien; Hilbert N Dricken, MD, Milwaukee; Paul S Emrich, MD, Oshkosh; Erwin E Grossman, MD, Milwaukee; Hubert D Grota, MD, Sturgeon Bay; Robert H Gunderson, MD, Beloit; Frederick G Hidde, MD, Sheboygan; William A Hilger, MD, Milwaukee; Charles M Ihle, MD, Eau Claire, Harold O Jirsa, MD, Ocean Springs, Mississippi; John W Johnson, MD, Withee; J Howard Johnson, MD, Sun City, Arizona; Lawrence W Kaufman, MD, Milwaukee; Charles P Kauth, MD, Port Washington; Lawrence J Keenan, MD, Fond du Lac; Richard L Kennedy, MD, Eau Claire; Charles K Kincaid, MD, Madison; Leslie G Kindschi, MD, Monroe; Willard E Klockow, MD, Muscoda; Edward E Krumbiegel, MD, Naples, Florida; Esther C Kurtz, MD, Madison; Howard J Laney, MD, Prescott; Mischa J Lustok, MD, Milwaukee; Albert G Martin, MD, Sarasota, Florida; Ralph B Pelkey, MD, Crivitz; Albert F Rogers, MD, Oconomowoc; Owen Royce Jr, MD, Milwaukee; Ernest V Smith Jr, MD, Fond du Lac; Ruth S Stern, MD, Milwaukee; Katherine W Stewart, MD, Eau Claire; Abe A Sverdlin, MD, Milwaukee; Charles A Vedder, MD, Marshfield; William L Waskow, MD, Phoenix, Arizona; Donald M Willson, MD, Milwaukee; and Raymond G Yost, MD, Manitowoc. (Photo by Ben Bartel)■

The *Wisconsin Medical Journal* gratefully acknowledges publication support of this "Blue Book" issue through a contribution from the **Crownhart Memorial Account** of the State Medical Society's Charitable, Educational and Scientific Foundation.

Task Force on Medical Care: ***Back row left to right:*** *(inset) John Oujiri, MD, Ashland; Irvin J Bruhn, MD, Walworth; Melvin S Blumenthal MD, Monroe; Milton F Stuessy MD, Platteville; James L Craig MD, New Richmond; Joseph B Durst MD, La Crosse; DeLore Williams MD, West Allis; Duane W Taebel MD, La Crosse; Frank H Urban MD, Wauwatosa; Mr John Meurer, Madison; (insets) Jack Strong MD, Mauston; Arnold J Brown MD, Madison; and Juanito Singson MD, Milwaukee.* ***Front row left to right:*** *Paul D Nelsen MD, Ripon; Richard G Roberts MD, Darlington; Donald R Griffith MD, Eau Claire; Henry F Twelmeyer MD, Wauwatosa; Lee M Tyne MD, Brookfield; Rolf S Lulloff MD, Green Bay; Timothy T Flaherty MD, Neenah; William J Maurer MD, Marshfield; Pauline M Jackson MD, La Crosse; William E Raduege MD, Woodruff; Joseph D Lewis MD, West Bend; Richard N Odders MD, Racine; and Walter E Gager MD, Waukesha. Others on the Task Force not pictured: P Richard Sholl MD, Janesville; George Collenttne MD, Milwaukee; James Kuplic MD, Sheboygan; Clarence Klasinski MD, Stevens Point; Robert Shapiro MD, Madison; and H Myron Kaufman MD, Elm Grove.*

SMS Task Force on Medical Care

Requested by the 1984 House of Delegates, the State Medical Society's Task Force on Medical Care eventually involved 32 Task Force members and 96 additional Work Group members appointed by SMS President Timothy T Flaherty, MD.

The Task Force was charged by the House with an examination of the major socioeconomic trends and issues facing physicians in Wisconsin. The Task Force conducted its research and analysis through five Work Groups on Reimbursement and Delivery systems, Quality of Care Issues, Competition and Regulation, Hospital-Medical Staff Relations, and Physician Contracting and Negotiations.

The Work Groups and ultimately the full Task Force offered over 120 recommendations on how SMS should pursue a resolution of these socioeconomic problems. The recommendations ranged from basic statements of policy on such issues as capitation payment for physician services to proposals for a restructuring of the Society and its staff and financial resources to provide contracting and negotiation services to SMS members.

The entire package of Task Force recommendations was accepted by the 1985 House of Delegates for referral to the SMS Board of Directors for study and possible implementation.

Copies of the final reports of each of the five Work Groups as well as the Task Force's implementation strategy are available to Society members from the Physicians Alliance Division at SMS headquarters in Madison (Phone 1-800-362-9080 or Madison area 257-6781).■

"A full and promising agenda already laid out

. . . one that offers firm direction for our Society, focuses on opportunity as well as problem, offers a positive outlook, and creates a plan rich in reward for both doctor and patient."

Report of President Scott to the House of Delegates

As I MOVE OUT of the comfortable shelter of being "number 2" in the State Medical Society heirarchy, I can't help but consider what the next year holds, not alone for me, but for all of us—and our patients. We have been blessed this past year with the leadership provided by Doctor Flaherty. We are all the better for his spirit and his deeds. Thank you, Tim.

I believe that I am arriving at the presidency of the State Medical Society at a most favorable time—for me and my beliefs. Moreover, I believe we are looking at a time more favorable than the recent past for all dedicated physicians and their patients.

This view may prompt some of you to wonder if I have lost touch with reality, that I am dreaming of days gone by. Let me explain why I believe the future favors both physician and patient, why I am full of hope, not despair.

First, I come into the presidency with a full and promising agenda already laid out for me. It is an agenda put together by the Society's Task Force on Medical Care.

To everyone's good fortune, nearly 140 physicians of every diversity became part of this Task Force and its work groups—young and old, rural and urban, specialist and generalist, group and solo, employed and independents, medical school and private practitioners, the hope-less and the hope-full.

They have prepared an agenda that offers firm direction for our Society, focuses on opportunity as well as problem, offers a positive outlook, and creates a plan rich in reward for both doctor and patient. I congratulate each of you—physicians and staff—for your role in the Task Force.

Not only am I favored to have such an agenda handed to me on the brink of my inauguration, I am favored with a deep sense of commitment by all on the Task Force and the Board of Directors to help give life and vigor to these new-born objectives.

Next, I believe there is a more favorable time ahead for physicians, bright lights at the end of what so many physicians regard as the dark tunnel of the future of Medicine.

To be sure, Medicine no longer holds sacrosanct the individual independence of action that led past generations of physicians to prize this profession.

But for all the changes—and more to come—I believe that tomorrow's physicians will quickly adjust to greater institutionalization, closer affiliation with groups and hospitals, a variety of for-profit as well as non-profit entities, and even governmental agencies.

These may not be the highest order of my personal preferences—after all I am now in my 27th year of practice—but even this "old dog" can learn a few new tricks.

I have but to look at my own county—Dane—to see the dramatic changes that have taken place in the reordering of delivery mechanisms. Just two years ago the 1,200 physicians in my county were competing in the traditional sense with a collegiality that most regarded as ideal. Today, Madison is regarded as the hottest HMO town in America—some physicians have folded—like farmers in economic distress—cut off from their patient "market" and unable to withstand the price wars of capitation. Others have been remarkably flexible in adapting; hopefully without sacrifice of quality or concern for the patient.

Statewide we have seen a tripling of enrollment in HMOs and other "institutions" of medical care in the past two years. There are now at least 25 HMOs or other prepaid plans, plus their countless satellites with

a total enrollment of almost 750,000 persons, nearly 15% of the state's population. And the growth continues at a record rate. No county, no town is so isolated as to be unaffected by this movement.

I believe that the young men and women now emerging into practice will come with well-conceived and well-indoctrinated concepts of how to provide quality medicine in a practice environment that some of us today view as hostile.

Our system of medical education is already moving to prepare them for a different business, social and political climate than when we entered practice. That is good—for I believe we will continue in our medical schools to emphasize the basic elements of scientific excellence in diagnosis and treatment—but now with greater attention to the doctor's role in prevention on the one hand and how to make the most of longevity, on the other. In addition, I see specialization as emerging from the cacoon of its narrow pathology to view the patient as a *whole human being* albeit with problems affecting its parts.

> *"The time is favorable for a renaissance of virtue in medical practice . . . the truest guardian of good patient care remains the physician with a good conscience . . . virtue is an inevitable companion of true competition."*

I believe that the time is favorable for a renaissance of virtue in medical practice—virtue as understood by my father, an EENT physician in Massillon, Ohio—virtue honored by him throughout his more than 25 years of practice.

He believed as I do, the words of H L Mencken that "conscience is the inner voice that warns us somebody may be looking." In those days it was mostly one's own conscience that stood guard over what was good treatment and fair dealing for the patient. Despite the innumerable government regulations and competitive schemes we have today, the truest guardian of good patient care remains the physician with a good conscience.

Medicine is not practiced for governments. It is not practiced for insurance companies or HMOs or PPOs or IPAs. It is not practiced for hospitals, or for that matter, doctors. Medicine is practiced for people.

It embodies a skill, and most of all a desire, by the doctor to prevent disease or injury in human beings; a dedication to give each patient the opportunity to enjoy a better quality for his or her life.

I believe that the pressures of competitive practice actually favor the growth of moral excellence in today's practitioners. It is almost startling to note that "marketing"—a term that makes most physicians wince—turns out to be nothing more than good old fashioned virtue in 20th century trappings.

All of a sudden, the medical literature is full of admonitions to do right by the patient! Public relations entrepreneurs are making a good living telling physicians what they have been taught for centuries:

- —Medical technology produces better results when there is a good relationship between doctor and patient.
- —A majority of complaints by patients about their physicians arise from a failure of communication.
- —The patient expects to know what we are doing to justify our charges.
- —The patient has an absolute right to be told all the reasonable details of his or her problem, options for treatment and possible outcomes. Incidentally, attention to this maxim can have a highly favorable impact on our malpractice dilemma.
- —Showing care and concern for the patient speeds recovery, offers satisfaction if not always hope, and quite incidentally, beefs up the public's image of the physician.
- —Treat the patient as you would like to be treated.
- —When all else fails and the patient's life is to end, share in the grief of that time. After all, death is a part of the physicians' life, and grieving has its own way of healing.

Yes, I believe this is a favorable time for the exertion of virtue, as old or as new as you wish to regard it. I believe virtue is an inevitable companion of true competition.

Price is seldom the deciding difference when a patient chooses from a host of technically excellent professionals.

The real difference is in how the doctor *feels* for the patient—something that isn't sold with ads, but is sensed by the patient in face-to-face encounter with the physician.

Finally, I believe that favorable times are ahead for the patient. It is indeed true that getting care is increasingly complex for the patient.

Substantial barriers of communications and understanding are imposed upon the patient by new delivery systems and the conflicting messages he or she receives from a technologically progressive but outcome-imperfect profession, from a nation which touts its medical achievements but heaps disdain upon the integrity of its medical practitioners, from a government which promises healthcare for the elderly but delivers reduced benefits, baffling red tape, and not-so-subtle hints of rationing yet to come.

But I believe that our own dedication to standards of what is right for the patient will continue to move our state and national health policy in a direction that ultimately will see the patient as we see the patient—in need and deserving of compassionate and skillful

physicians—and the opportunity for reasonable access, availability and cost in medical care.

These favorable trends for the patient are all the more likely to be realized because of the new emphasis on another old virtue—the physician as advocate *for* the patient. Let me illustrate:

Recently, the Board of Directors of the Society approved and implemented what it calls the REACH program—"Resource for Education and Awareness of Community Health." This program reaches out to the public on behalf of the Society's member physicians to tell the doctors' story, to educate, to inform, to urge action for better health, to help patients obtain quality care at reasonable cost.

I don't know who authored these words taken from the REACH document, but they say exactly what I believe every physician should say to his or her patients. I quote:

"I am your physician. I will speak for your interests at all times, you have asked that I take care of you. I will do so to the very best of my ability. You can trust me to work for your best interests. There is no doubt as to whom I am serving or what I am doing. I do it for you."

With such a commitment to advocacy for our patients, the members of the State Medical Society—strengthened by the advocacy services of their state organization—can bring reality to the favorable outlook I predict for medical care in Wisconsin.

Advocacy is not easy. It demands our constant attention. It might mean filing a suit to protect the right of the patient to choose his or her own physician. There will be time when even closed panel contracts, thoughtfully entered into, may need to be broken for the best interest of the patient.

It may mean protracted litigation or negotiation to preserve the patient's rights to reasonable reimbursement or benefits under some delivery system, some DRG program, some government edict.

Advocacy is not always popular. It may mean—as now—serious challenge to deeply ingrained precepts of justice that are no longer able to contain the legal and economic abuse which threatens our malpractice system.

It may mean immediate, aggressive, and costly analysis and attack on the newly announced regulations for publication of hospital and doctor specific data on treatment methods, outcomes, and charges—data gathered by PROs still reeling from the rapid and ever-changing onslaught of regulations requiring the compilation of information from uncertain and unseasoned review systems designed more for cost control than for quality assessment.

Advocacy is often difficult. It demands—as at this moment—that we confront our own inadequacies—to recognize, and help our patients to understand that we cannot *guarantee* perfect outcomes in the care we provide. It demands that we face our own colleagues whose techniques of intervention, however well intended, fail to meet a standard of practice that we recognize as giving the patient a reasonable opportunity for recovery or well-being. It demands that our Medical Society openly and proudly set forth its own program of patient protection from abuse or malpractice.

Advocacy is personal. When the patient reaches out for solace, whether in fear or insecurity or grief, he does not reach for a procedure manual. He does not reach for the bylaws of the hospital or the HMO. He reaches for his physician's hand . . . and he must not reach in vain.

Ladies and Gentlemen of the House, you have put your faith and trust in me as your president this year. I have had good teachers in Dr Timothy Flaherty and our Secretary Earl Thayer. I will do everything in my power to uphold the excellence of leadership in our State Medical Society. Advocacy for the patient is our theme. A good doctor-patient relationship will survive all the pressures that can be put upon the medical profession now or in the future. ■

"Our number one priority is malpractice reform

. . . We have identified the problem, we've identified the solutions, we need action teams to talk to other practitioners, to talk to employers, to talk to hospital administrators, to talk to our attorneys, and most importantly, to talk to our legislators."

Report of Outgoing President Flaherty to the House of Delegates

THIRTEEN MONTHS AGO during our 1984 Annual Meeting our theme questioned, "Whose responsibility is the cost of medical care?" The moral dilemmas that are faced by patients, physicians, hospitals, and third-party payers as they grapple with healthcare costs were debated and discussed under the guiding gavel of the moderator, Dr John Simenstad. The questions posed highlighted society's responsibility to ethically provide every person with an adequate level of healthcare without excessive burden to anyone while simultaneously asking, "What is an adequate level of care?" and "What will it cost?"

In my report to the House of Delegates I called for increased physician involvement in Government as Government becomes more involved in Medicine. I defined our challenges as medical liability, competition, contracting, and Medicare assignment. You, the House of Delegates, directed me to appoint a Special Task Force on Medical Care to prepare policy and strategy recommendations. Areas to be studied were delivery systems, methods of reimbursement, how to preserve quality of care, fair competition, medical staff hospital relationships, Government controls on healthcare, problems of medical liability, approaches to negotiations with third-party carriers, and other germane issues.

AMA President Dr Joseph Boyle addressed the House of Delegates and his message was one of patient advocacy and the professional ethic.

Reflecting on that beginning, my term of office can be likened to stepping into a prize-fighting ring with you (SMS member physicians) in my corner and a managerie of tag-team opponents on the other side of the ring waiting to get in their punches. We, however, landed the first blows repealing cardiac surgery decertification on March 28, and then watching the Senate on March 29 floor the chiropractic bill (AB 824) by a vote of 19-10. This re-emphasized President Eisenhower's theme "Politics should be a part-time occupation of all (physician) citizens." Prior to legislative adjournment on April 6, SMS netted victories with enactment of a bill revising the Patients Compensation Fund, Malpractice Panels, and WHCLIP. However, these improvements in the Patients Compensation Panel System were too little and too late to divert the cascading malpractice crisis. All in all, SMS had a successful 1984 legislative session; the legislators went home; and to paraphrase Will Rodgers, we felt safer.

On April 16 and 17 I participated in the first of many forums on healthcare costs. This initial forum was sponsored by Congressman Les Aspen and was entitled "Skyrocketing Health Care Costs—Whose Got the Cure?" The audience for these seminars was primarily senior citizens, a group with whom physicians share many common goals and for whom we have great respect reflecting on their unique contribution to our society. We, as the audience heard an alarming message from La Varn Taylor of the House Budget Committee and Joeyln McDonald, a legislative assistant for Congressman Richard Gephardt of Missouri. They, from their perspective, (budget and Congress) painted a dismal picture for the Seniors, of decreasing Federal resources for payment and increasing demand produced by projections of dramatic growth of eligible Medicare recipients. Representatives of the local hospitals and I gave our perspectives. Congressman Les Aspin refereed. We took a few punches but also attracted many of the senior citizens to our corner as they realized that we (Organized

Medicine) were really their advocates.

In May the SMS Board of Directors "put up their dukes" with the sponsorship of a new professional liability insurance plan for the physician-members of the State Medical Society. The Professionals, an arm of PICO (an Ohio Medical Association sponsored plan) presently has over 1,500 Wisconsin physician-subscribers in its liability insurance program with SMS physicians controlling claims management and underwriting.

In late May and June Governor Earl and the Health Policy Council, with the help of local HSAs, "set up the rings" in a number of Wisconsin cities asking the question, "What should the State Government do to control healthcare costs?" SMS stepped into the ring and delivered a salvo of replies. We recommended:

1. Sponsorship of medical liability reform
2. Repeal of CON
3. Support for legislative antitrust relief
4. Scientific study of supply of physicians and allied health personnel
5. Reorganization of the Department of Health and Social Services
6. Continued emphasis on patient cost-sharing in health plans.

At the same time we delivered a "short jab" reminding those present that the SMS Board of Directors in January had supported a temporary freeze in fees for Medicare, that became a National program in February when the AMA called for a national physician fee freeze and 80% of American MDs said "Yes." This has been estimated to have saved Americans 1.5 billion dollars in healthcare costs in 1984-85. Another "jab" seemed to open the eyes to the fact that this Society's physicians had provided thousands of dollars in free care through free clinics and the ShareCare Program in Wisconsin.

On June 19, another "fighter" entered the ring with the appearance of the reorganized and merged Wisconsin Peer Review Organization (WiPRO) receiving the Medicare contract on June 27, 1984. Some physicians believe that WiPRO sometimes tends to throw punches indiscriminately; however, its "trainer," HCFA, may be responsible for teaching dirty tactics.

Between rounds, in June, Dr Patricia Stuff lost an election but won the hearts of the AMA Delegates in Chicago.

During the same time-frame, Congress tried to land a "low blow" with mandated Medicare assignment. However, the organizations of Medicine blocked that illegal punch and neutralized it with a House of Representatives floor vote. In the next round a small clique of pugnacious Potomac pugilists tried to land an identical "low blow" through a Congressional Conference Committee with the "punch" being sidestepped at the last second. With the encouragement of the "Presidential Referee" and his cornerman, "the Reverend Stockman," a combination of a rabbit punch, thumb in the eye, and a blow just below the inguinal ligament was delivered to American physicians. Although disguised to the Medicare recipients, the Medicare fee freeze and the participation scheme had landed. The AMA jumped in the ring and filed a legal protest in Indiana which is still to be resolved.

Back in the "Wisconsin corner," the Commissioner of Insurance issued the PPO rules. SMS received a six-year reaccreditation by the Council for continuing medical education and I appointed 35 SMS members to the Task Force and 129 SMS members to the five work groups of the Special Task Force on Medical Care. These physician volunteers represented all practice types and geographic distribution. Special Legislative Council Committees on medical liability, primary prevention, bioethics, graduate medical education, and nursing home regulations were appointed with SMS members on each Council carrying our message into the ring.

> *"Our strength lies in our unity and every physician must recognize the need to be unified. We, as individual physicians and as an organization of physicians, must continue to do what is best for the patients of Wisconsin and I am confident this will always prove best for the physicians of Wisconsin."*

On August 8, the Insurance Commissioner, Thomas Fox, grabbed the ring microphone and announced that Wisconsin was facing a medical malpractice insurance crisis (August, '84) that may be worse than the mid-70s malpractice crisis. That announcement launched a massive audience educational effort by SMS identifying the *specifics* of the malpractice crisis.

Also in August, the "most distinguished" Legislative Council Special Committee on Health Care Provider Systems (on which I served) recommended the elimination of Blue Cross/Blue Shield United of Wisconsin's tax exemption. The vote was 10-1 (Brad Wilson of BC/BS also served on the Council) to eliminate the property, sales, gift and inheritance tax exemption enjoyed by BC/BS.

AMA and SMS objected to the "stranglehold" attempted by HCFA of the attestation requirements for physicians relating to discharge hospital coding. This objection was upheld and the "stranglehold" was reduced to a "bearhug" attestation requirement.

On September 1, a "long looping, preadmission review, right cross" was landed and for a month or so Wisconsin physicians were hearing "busy signals"

in their ears or messages they had difficulty understanding.

Two clear messages were delivered by the SMS, Auxiliary, and CESF Workshop on Health attended by over 2,000 high school students and counselors: one at UW-Stevens Point on dangers of substance abuse and the other on the agony of teenage suicide at UW-La Crosse; a true defensive effort on behalf of Wisconsin's young adults.

In October the bell sounded for the next round to be governed by the "Carolyn Davis participation rules." AMA's counterpunching delayed the implementation of the rules to October 15 but the final decision as to their constitutionality awaits the judgment of a Federal court.

On October 9 SMS landed one of its most "uplifting blows," the effects of which are having a lasting influence in Wisconsin. In a letter from Dr Darold Treffert, Chairman of the Board of Directors and from your President, SMS physicians were urged to offer "special considerations" to all patients facing financial hardship. SMS physicians were asked to consider accepting assignment or to offer reduced fees, when appropriate. You have backed this punch with your participation. This effort, on behalf of Wisconsin's less fortunate citizen, has re-emphasized our commitment to advocacy of our patients and has produced a chorus of support in our corner by concerned Wisconsin citizen organizations such as Wisconsin Coalition for Aging.

Also in the Fall, the SMS Board of Directors leveled a clean punch at HFCA over the tactics it used in implementing the PRO legislation nationwide. HFCA deserved the punch with their PRO contracting process which created unrealistic and probably unachievable objections. This has the potential to mislead the public and divide a profession already dedicated to quality assurance, and further, to needlessly open wounds that may develop into a malpractice cancer.

On November 10 at our Leadership Conference a champion of American Medicine, AMA President-elect Harrison Rogers was brought into the ring and he stressed the importance of physicians keeping their national, state and county medical societies financially viable during these times of rapid change in the medical care system. He told our young "golden glove fighters" (the medical students of today) of their responsibility to protect the health of their patients through their membership and support of medical societies. His message is being heard around the country with a dramatic increase in student memberships in the AMA.

The AMA, in December, tiring of the "illegal blows," "bias of the Referee," and the sometimes "inexplicable boos" from the crowd, voted to ban both amateur and professional boxing. However, during the same time, SMS was putting up a great defense and also landing offensive blows in the Special Legislative Council Malpractice Committee where strengthened peer review, a cap of $1,000,000 on awards and limitation of attorneys' fees to a sliding scale were approved by the Legislative Council Committee.

We crowned a champion in Milwaukee. Dr Leo R Weinshel was named 1985 Physician-Citizen of the Year by the Wisconsin Chamber of Commerce for his distinguished professional and community-oriented career. As stated in his award, concern about people and helping them has been a way of life for Doctor Weinshel. Because of his example the community cannot help but better understand and appreciate the role of Medicine as well as the contributions made by the medical community as a whole.

SMS sent a holiday message to Governor Earl as he was making his budget shopping list. We objected to his proposed increases in mandated insurance benefits and expansion of mental health gatekeeper function. We urged him to increase funding for public health activities and asked him to reconsider his HMO promotion which will utilize state funds to subsidize HMO premiums for low-income elderly.

January was a defensive round, participating in the medical alert on diethylstilbestrol (DES), explaining the delay in DPT boosters, testifying at the special joint meeting of the Assembly and Senate Health Committees and participating in a panel concerning the issue of uncompensated care. We objected to the proposed elimination of CME requirements for medical licensing in Wisconsin and then were *"floored"* by the one-two punch of a proposed 70% increase in WHCLIP premiums and 160% increase in the Patients Compensation Fund premium for 1985! We picked ourselves off the canvas and counterpunched effectively with facts included in our "Special Update on Medical Liability" which was distributed to SMS members, legislators and CEOs of Wisconsin's major corporations. This produced a shower of letters on the Insurance Commissioner and our legislators.

Dane County Circuit Court sent several trial lawyers to the showers, halting their attempt to get SMS records in a Milwaukee malpractice case. We picked up the malpractice fight with offers of peer review "punching power" to the Medical Examining Board and to the Patients Compensation Fund to serve as a resource to the MEB for screening panel cases, making recommendations regarding prioritization, and also determining if negligence has occurred in malpractice settlements and panel awards. On March 10 we marched around the ring with quarter-page newspaper ads concerning reasonable expectations of medical care. On March 28 more than "50 gladiators"

representing county and specialty societies gathered in Madison to review and develop malpractice strategies.

Suddenly, out of a neutral corner, and while concentrating on the malpractice opponent, we were "rabbit punched" with a blow delivered by a glove containing a role of the Susan B Anthony dollars, bashing us into a posture where physicians, hospitals, etc, must accept a continued physician and DRG payment freeze in the spirit of unilaterally supporting the burden of the Federal deficit dilemma. This continued freeze beyond the legislative mandated fifteen months will result in physicians being paid in 1986 at levels based on 1982 charges. This now has produced concerns among other groups, namely, the AARP, AFL-CIO, and others.

This month we are trying to improve our "reach" to produce better punching power. REACH, which stands for *Resource* for *Education* and *Awareness* of *Community Health* is the SMS program to improve physician public communications. This brings us to La Crosse, 1985, with our Annual Meeting dedicated to "Cost-effective Care" of the geriatric population.

Wisconsin physicians are tired of being the object of "low blows and rabbit punches." In resolutions 9, 10, and 11 we are now considering banning boxing.

No matter how we do it, Winston Churchill was right: "there is so much yet to be done." Our number one priority is malpractice reform and that's coming! Let me share with you two excerpts from letters. First is from Dr Ralph F Sortor who practices obstetrics and gynecology in Hales Corners. It reads in part, "I am concerned that we are the only individuals whose license to do business in Wisconsin exists only so long as we contribute to a Compensation Fund for all citizens. You will note that Worker's Compensation applies not to some, but to *all* employers. The premium proposed for 1985 is impossible. I cannot afford the Patients Compensation Fund premium for doing obstetrics. There is no way to raise my fees to cover it. That $34,613 premium plus the interest on it, even at the prime rate would cost me $3,274 per month, plus all of my other overhead, just to stay in business. I have practiced Ob-Gyn in this state for 27 years. I have never had a civil judgment against me, not even for malpractice. I have never had a case go to panel. I have never had any private insurance carrier drop me from its coverage. I have been a valuable constructive citizen of the state. *I should not be forced out of business.* (He concludes his letter with a quotation from Thomas Jefferson's First Inaugural Address, 1801.) 'All, too, will bear in mind this sacred principle, that though the will of the majority is in all cases to prevail, that will, to be rightful must be reasonable; that the minority possess their equal rights, which equal laws must protect, and to violate would be oppression.' "

The next letter is dated March 5, 1985 and is in response to a physician constituent by State Representative John D Medinger of La Crosse, the assistant majority leader, and it says, "Thank you for your recent letter expressing your strong concern about the recommendation to dramatically increase payments to the Patients Compensation Fund and other aspects of our medical malpractice crisis. Like you, I am very concerned about this situation. It is a problem that affects all of us in the state, not just the medical community. It is also an immediate problem the Legislature will have to address in the next few months.

"You may know that I am a member of the Special Study Committee on Medical Malpractice. We have reviewed the problem and have looked at scores of suggested changes in the system. At this time, it is too early to accurately predict what will be recommended by this study committee. We will meet again next month. Physicians, lawyers, insurance company representatives, members of the public, and legislators all have deep-felt convictions and various 'solutions.' It is now time to quit studying the problem and to act.

"As you are probably aware, this letter, due to the *large amount of mail* I have received on this subject, is more or less a form letter. This, I must say to everyone that I am perturbed and quite irked that some of the letters I have received actually blame the legislators for this crisis! I am not with you in the operating room, I am not on the juries which grant outrageous awards, I am not an insurance company representative, and I have never advised anyone to settle out of court for a huge award. I am not even a lawyer!! What I am is your State Representative. Let's not point fingers, let's work together. Identifying the problem is easy. Now let's get on with the difficult part.

"I want to assure you that you have my attention. I will do all I can to improve the situation and to seek an equitable solution for all concerned parties."

Thus, we (SMS) have identified the problem, we've identified the solutions, we need action teams to talk to other practitioners, to talk to employers, to talk to hospital administrators, to talk to our attorneys, and most importantly, to talk to our legislators.

The number 2 priority is membership; SMS *does* represent all of the physicians of Wisconsin. I think it's our responsibility as supporting members of SMS to contact our nonmember colleagues and use the lobbying credo, "If you can't make him see the light, make him feel the heat." Our strength lies in our unity and every physician must recognize the need to be unified. We, as individual physicians and as an organization of physicians, must continue to do what is best for the patients of Wisconsin and I am confident this will always prove best for the physicians of Wisconsin. ■

"The problem of competence or incompetence . . .

in some physicians . . . and what to do about it. We must now cry out for public support to change the laws as necessary to permit legitimate peer review and discipline by the medical society and hospitals without fear of antitrust violation."

Report of Secretary Thayer to the House of Delegates

My report today deals with a subject that has long been with physicians. What's new about it is the enormous attention it is attracting these days from the media and legislators. It is rapidly becoming a key issue in the resolution of the malpractice problem. Thus, its importance cannot be underestimated. I speak of the problem of competence or incompetence in some physicians . . . and what to do about it.

I realize that I tread on sensitive ground. I am not a physician. I cannot and do not attempt to judge the competence of physicians.

But for thirty years plus, I have worked with physicians, seen a great deal of good and some bad, been faced with innumerable complaints about physician care, heard the gripes of the public about this issue, listened to physicians who literally beg for some means to be relieved of the stigma that comes from knowledge of aberrant practices. I have worked with our Mediation and Peer Review Commission and our Statewide Impaired Physician Program. Many states have given up dealing with the former; as for the latter, we have a model program with close and continuing linkage to the Medical Examining Board.

Like the physicians, I wince every time another headline attacks the Medical Examining Board for allegedly failing in its public responsibility to properly "rout out the rotten few," as one news story declared. Even though these attacks are against a state agency, they are attacks, in effect, on physicians and their competence.

I have just received letters from three highly respected physicians, leaders of the profession by any standard.

One of them says: "Legislators repeatedly tell me that we have to clean up our own house before they will act on the malpractice issue. They simply don't know how difficult this is." He cited the situation of a physician in his locality whose treatments he feels are useless. He went on to say, "Neither my specialty society nor myself will take this man on for fear of countersuit. No physician can place his own life in jeopardy in the effort to eliminate a malpractitioner . . . under the current system."

Another doctor writes: "It is absolutely critical that we develop an efficient avenue for ridding the medical profession of the quacks, charlatans, and incompetent practitioners that appear in our ranks. Everyone is afraid to rise up and take action against them for good reason . . . legal reprisal. This is a public issue, and it is seriously threatening our profession. If we do not help clean up our act, it will be difficult for us to maintain credibility with society in general whose aid we must certainly solicit in order to effectively deal with the current problems of malpractice."

Still another physician writes: "We must announce our own private sector effort to do something about this issue. The only agency that can truly analyze the quality of one's work is another physician who is free of any encumbrance that would interfere with the effort. I am sure some of our members will wonder why in hell we are dipping our fat heads into something so controversial, and I know that the majority of physicians do a good job and should be praised. Therefore, I feel that our effort would result in praise for the good and doing something effective about the bad."

Dealing with the incompetent or aberrant physician has always posed a problem. In 1904—81 years ago—the *Wisconsin Medical Journal* reported that the State Medical Society was under fire from a group of its own

members because it was advocating that statutes be enacted to require physicians to show evidence of accredited medical school graduation before being licensed in Wisconsin. To oppose the Society in its well-intended effort for the public and professional good, several physicians organized the Wisconsin Medical Union—the first physician union in Wisconsin, if not in the country. A circular put out by the union said that its objective was "to unite the liberal minded physicians," among them homeopaths, eclectics, and physiomedical practitioners, for "mutual protection against unjust statutes."

The editor of the Medical Journal commented about the officers of this union:

> "One poses as an electro-therapeutist, but formerly practiced vita-therapy."
>
> "A second is the graduate of a diploma mill whose organizers have since served time in Joliet."
>
> "A third and fourth are graduates of the famous Milwaukee Eclectic College which, in reality, existed only for the sale of diplomas."
>
> "A fifth is practicing under a certificate of registration issued by the Wisconsin Board of Medical Examiners. He bought a diploma from the Illinois Health University, but perjured himself in obtaining a certificate of registration by claiming that during the year 1898, he was practicing in Wisconsin when as a matter of fact he was serving time in Waupun for adultery."

The editor of the Medical Journal continued with this concluding note: "We are told that this information has long been in possession of the State Board of Medical Examiners, but they have thus far neglected to take any action on this matter."

The familiar ring of those words prompts me to suggest that we dare not wait another 81 years to deal in a forthright manner with the issue of the profession policing itself. We must no longer excuse inaction by the Medical Society or the hospital by saying, "FTC won't let us do that." There is some truth in the excuse. But we must now cry out for public support to change the laws as necessary to permit legitimate peer review and discipline by the Medical Society and hospitals without fear of antitrust violation.

We must openly confess to the public that the State Medical Society, while it can and does discipline some of its members for inappropriate practice actions, has none of the ultimate clout necessary to remove a physician from practice. Such authority rests only in the hands of the Medical Examining Board which, contrary to some publicity, is properly and totally independent of the State Medical Society.

The Board is a state agency. The State Medical Society is not. If the Society is to deal with the problem, it must be given the legitimate authority to do so. If it is not given such authority, those who cry out for the Society to "police itself" must cry out to the Medical Examining Board or to the Legislature.

On the other hand, the Society cannot and must not pull into its professional shell because it doesn't have the ultimate authority. The Society instead must openly, publicly, energetically, and immediately expand its present efforts in peer review to pursue a vigorous, organized, and calculated effort:

1. To prevent or reduce the number and frequency of malpractice suits by removing or reducing the reasons for suits—a significant percentage of which, according to physician-owned liability carriers, are meritorious.
2. Identify and bring under review in a prompt and decisive fashion those physicians whose conduct appears to represent standard practice—including, but not limited to, those physicians for whom claims have resulted in payment to plaintiffs on multiple occasions.
3. Revamp our disciplinary procedures to a degree that is acceptable to both an aware public and an enlightened profession.

I suggest that the Society begin immediately with appointment of a special task force of SMS members supplemented with the necessary legal and other talent to coordinate the Society's work in this field with the current efforts of the state Legislature and the Medical Examining Board. A number of proposals should be considered:

1. Let us begin with the Governor. The credibility of the Board as a disciplinary body and, to a substantial degree, its ability to adequately perform its functions will depend on the quality of the Governor's appointees. There have been occasions in past years when those appointments were less than sterling. It is time for the Governor to look *only* for quality of person and practice, not quantity of political contribution, as the primary criterion for appointment to this Board.
2. The workload of the Board falls heavily on eight physicians of the current 10-member Board. They are the principal individuals responsible to evaluate the competence of physicians who come before them. With the current volume of complaints filed with the Board—some 300 per year—it may be necessary to expand by two or three the number of physicians on the Board, or to authorize that Board to delegate certain peer review functions to contracted physicians in various specialties. The State Medical Society Medicaid Medical Audit Committee, which has such a contractual relationship with the Wisconsin Department of Health and Social Services, is regarded as a national model of an effective way to accomplish necessary review by competent individuals in a timely fashion to serve the interests of the public. The Medical Examining Board should immediately consider such contracting for its work.

3. Civil immunity must be provided without equivocation to all who act in good faith in any capacity associated with bona fide peer review processes, including protection for those who simply inform the MEB of alleged inappropriate medical care or practice. Without this protection, we will never have an effective investigative or disciplinary system.

4. SMS, together with the Patients Compensation Fund and all primary carriers must jointly establish a coordinated incident reduction program aimed at better management of patient care, the use of widely accepted malpractice prevention techniques, and public education for better understanding of medical liability, the risks of medical and surgical treatment, and the role of over-expectation in the cause of liability actions. A Fund fearful of a $74,000,000 deficit this year certainly could spare at least $100,000 per year to help stem the "flood" of alleged malpractice incidents. By the way, let's put the situation in perspective. There are some 50,000,000 individual patient-physician encounters in Wisconsin every year. Some of these encounters, about 400 each year, lead to allegations of malpractice. While each of those is unfortunate, it must be noted that only 400 out of 50 million encounters produce a result so serious as to initiate litigation. One-third of these are soon dismissed as without merit.

5. The Medical Society in its sponsored liability plan, "The Professionals," and possibly the Patients Compensation Fund for all practicing physicians should seriously consider mandatory participation in risk management programs as a condition of continuing liability coverage. In fact, such a requirement may be a useful replacement for the present law mandating general continuing medical education.

6. The SMS, with legislatively required support from the Insurance Commissioner's Office, the MEB, and the PCF, should undertake continuing data collection and analysis of all medical liability claims including claims settled at any stage. The absence of accurate information on the etiology of medical liability claims in Wisconsin is nothing short of appalling given the enormity of the economic, legal, medical, and social problems associated with this issue. Without availability and analysis of this data, the reporting requirements currently being proposed will produce valuable information which may well go unutilized as a critically needed management tool for the control of medical malpractice.

7. Senator Van Sistine has called for improvements in the credentialing and peer review process of hospital medical staffs. The State Medical Society and WHA have assured their cooperation. This is no small task. We must get at it.

8. We must seek immediately some responsible way to integrate into the entire peer review process the findings of PRO (WiPRO) and similar peer review efforts undertaken on a private basis. At the very least, this requires the convening of a group representing the SMS, WHA, MEB, PCF, PRO, and probably legislative and insurance interests. Hospital specific data has now been mandated for release to the public render Medicare. Private patient data is next.

9. We must pass laws permitting WHCLIP and the Wisconsin Patient Compensation Fund to surcharge physicians who have repeated malpractice settlements or awards. This may be the fastest, easiest way to control the problem.

10. Finally, and perhaps most importantly, SMS should initiate immediate discussions with the Medical Examining Board, the Wisconsin Justice Department, independent attorneys, and members of the Legislature to seek an end to the frustration so frequently associated with the legal process of attempting to discipline physicians through the Medical Examining Board. Highly competent and reputable physicians are justifiably cynical when the legal process seems so easily manipulated to save the bad doctor. It is said that all you need to beat the Board's rulings is a lot of money and a good attorney. There seems to be more truth than fiction in this remark. The Medical Society must raise hell with such a system, and the legal profession has the obligation to join in seeking a remedy. We should invite its participation.

There are undoubtedly other possible solutions. But we cannot afford to wait for someone else to start the action. The integrity of our dedicated physicians is at stake. The public says this is your job, your responsibility. They may not be totally correct, but they are not totally wrong either.

Last summer, I took my 17-year-old grandson on a fishing trip to Canada. One sunny afternoon when we tired of catching walleye, we let the boat drift in the light breeze and contemplated the quiet and the scenery. We had been discussing my work with the Society. With some hesitation, my grandson asked, "Just what is the Medical Society anyway?"

I was challenged to make a simple summary of the Society's many functions. Finally, I said the Society tries to do two things: "It tries to help doctors be better doctors—and it tries to help patients be healthier."

There was a brief pause and my grandson said, "Aren't those two the same thing?"

His perception of the Society should tell you as it does me that it is time to get moving with this matter of "policing ourselves." It will help you. It will help your patients. And, in the end, aren't those two the same thing? ■

Wisconsin Homecare Organization (WHO)

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A non profit organization working toward a goal of available, accessible, quality homecare throughout the State of Wisconsin in cooperation with the state-operated agency for enforcing home health licensure standards: Bureau of Quality Compliance.

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The United States Navy Medical Command desires physicians who want to practice medicine . . . not be business managers. The Navy offers specialists quality clinical experience and professional growth, a very comfortable lifestyle without financial and administrative worries, and the valuable time to spend with family and friends while planning the future.

- Flight Surgery
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- Neurosurgery

LOCATIONS: 23 modern medical facilities located along the east and west coast, as well as nine hospitals overseas, including those in Japan, Spain, Italy and the Philippines.

BENEFITS: Varied clinical experience; 30 days annual vacation; world travel benefits; full malpractice, medical/dental coverage; net starting salaries from $40,000 to $55,000; non-contributive retirement package which yields approximately $20,000 a year after 20 years of service, or $30,000 a year after 30 years.

MINIMUM QUALIFICATIONS: State license; US citizen; excellent professional references.

For complete details, call or send Curriculum Vitae to: Lt Nancy Hill, Henry S Reuss Federal Plaza, 310 W Wisconsin Ave, Suite 450, Milwaukee, WI 53203; 414/291-1529 (Call Collect)

Family Enhancement Program
A Prevention program encouraging families to help themselves and others

- ***Parents Places*** are centers for parents, providing opportunities to share resources, concerns, and information. Children are welcome. Childcare is provided.
- ***CONNECT*** is for young parents and their families. Parents under 21 may receive support from trained volunteers and participate in special programs.
- ***Parent Haven*** is a support network and group for adults in families that are experiencing problem behaviors with adolescents.
- ***Facilitator Workshops*** provide training for volunteer, parents, and others to lead support groups.
- ***Support Groups*** and ***Parent Workshops*** may include those for Fathers, Stepfamilies, Parents of Middle School Children, and Parents of Teens.
- ***Middle School Parents***
- ***Fathers Workshop***
- ***StepFamilies Groups***
- ***Parents of Teenage Parents***
- ***Dane County Task Force for the Prevention of Teenage Pregnancy.***

In Dane County . . .

- ***Parents Place West,*** 326 South Segoe Rd, Madison, WI 53705 (at Covenant Presbyterian Church). OPEN: Tuesday mornings, 9:30-12:00.
- ***Parents Place East,*** 2425 Atwood Ave, Madison, WI 53704 (at the Atwood Community Center). OPEN: Friday mornings, 9:30-12:00.
- ***Parents Place South,*** 605 Spruce St, Madison, WI 53715 (at St Mark's Lutheran Church). OPEN: Wednesday mornings, 9:30-12:00. OPEN: Tuesday evenings, 7:30-9:30.
- ***Parent Haven*** 605 Spruce St, Madison, WI 53715 (at St Mark's Lutheran Church). OPEN: Tuesday evenings, 7:30-9:30.

PHYSICIANS EXCHANGE

Family Practitioner. Marshfield Clinic Department of Family Medicine is seeking a BE/BC Family Practitioner for a new position. The physician joining the Clinic's expanding 5-member department will enjoy the support of one of the nation's largest multispecialty groups, share the philosophy of family-oriented care with a preventive focus, and enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Marshfield Clinic offers an excellent salary plus extensive fringe benefits. Please send curriculum vitae and the names of several references to: E Grady Mills, MD, Family Medicine Department Chairman, Marshfield Clinic, Marshfield, WI 54449 or call collect at 715/387-5168. p6-8/85

Internist to join satellite of multispecialty clinic in Madison, Wisconsin. Satellite is located ten miles from Madison and has one internist already practicing. Support from all departments anticipated from multispecialty clinic. Fringe benefits and salary attractive plus excellent working conditions, environment and associates. New satellite is growing and additional physician is needed to give our patients quality care. Send resume to Dept 556 in care of the Journal. p6-8/85

Obstetrician/Gynecologist, Board eligible/certified, for Green Bay metropolitan area. Large multispecialty clinic with excellent salary and benefits. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611 p6-9/85

Family Practice physician MD or DO Board eligible or certified. Contact Leon Gilman, 4957 West Fond du Lac Ave, Milwaukee, WI 53216 or call 414/871-7900. 6-8/85

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; e.g., copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

West Bend, Wisconsin, General Clinic, a (18) physician multispecialty group, is seeking physicians in the specialties of Internal Medicine, Family Practice, OB/GYN, and Pediatrics. First-year salary guaranteed. Corporate membership possible after one year. Excellent fringe benefits. Located in scenic, recreational area with close proximity to Milwaukee. Please contact Hans W Schmelzling, Administrator, General Clinic, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 6tfn/85

Family Practice Physician to share existing practice and fully equipped medical office in Waushara County. Salary plus incentives and opportunity for eventual purchase of practice. Excellent recreational area, a great place to live and raise a family. Send inquiries to Roy Grunwaldt, Administrator, Wild Rose Hospital, PO Box 243, Wild Rose, WI 54984; ph 414/622-3257, ext 212. 6/85

Internist-Infectious Disease Physician. The Racine Medical Clinic, a progressive cluster corporation of 32 physicians, is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 6tfn/85

Medical Director, Hackley Hospital, Muskegon, Michigan. Hackley Hospital, 361-bed general hospital, is seeking a Medical Director for Northwood Center, the hospital's 48-bed inpatient psychiatric unit. Candidates should be Board-certified, possess strong leadership skills and a commitment to multidisciplinary treatment. The Medical Director position is a part-time position, allowing the Medical Director to develop a strong independent practice. Excellent financial potential and ready access to boating, fishing, and hunting. For immediate and confidential consideration, please write: Gerald O'Keefe, PhD, Horizon Health Management Company, 1100 Jorie Blvd, Suite 230, Oak Brook, IL 60521. p6/85

Cardiology—partnership available in Waukegan, Illinois, between Chicago and Milwaukee. Noninvasive and general internal medicine. Affiliated with two hospitals, new office. Excellent first-year salary, then partnership. Charles Nelson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 414/785-6500. p6/85

Versatile Surgeon wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E Johnson, Ely Medical Center, Ltd, 224 East Chapman Street, Ely, Mn 55731; ph 218/365-3151. 6tfn/85

Psychiatrist. Full-time adult staff position in well-established HMO serving over 210,000 people in one of the leading metropolitan areas of the Midwest. Join excellent staff of 35 psychotherapists and seven psychiatrists. Outstanding benefits, competitive salaries and a flexible work week providing time for teaching and other professional pursuits. Send curriculum vitae to: Paul J Brat, MD, Medical Director, Group Health, Inc, 2829 University Avenue Southeast, Minneapolis, Minnesota 55414. 6-7/85

Attractive opportunity for a Board certified/eligible family physician to establish a new community practice. The family practitioner will be eligible for full-hospital privileges at Beloit Memorial Hospital, a medium-sized acute care facility. This opportunity offers a guaranteed financial and start-up package. Inquiries or CV should be directed to Gregory K Britton, Administrative Director, Beloit Memorial Hospital, 1969 West Hart Road, Beloit, Wisconsin 53511; ph 608/364-5104. p6-8;g9/85

Excellent opportunity for a Board certified or eligible internist to practice in conjunction with an 8-member Internal Medicine Department of a 26-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 6tfn/85

Family Practice physician needed to join five family practitioners and a general surgeon. Immediate opportunity in west central Wisconsin near La Crosse. $45,000 first year guarantee plus incentive. Excellent recreational area. Community hospital. Send CV to William L Simpson, Administrator, PO Box 250, Sparta, WI 54656; or phone 608/269-6731. p5-7/85

PHYSICIANS EXCHANGE

continued

Wisconsin, Southeast. Board eligible/certified family physician sought for independent practice in rural community of 2,400 located 20 miles from Milwaukee. 127-bed acute care facility located 10 minutes from newly renovated office. Call coverage available with family practice group in area. Negotiable first-year guarantee will be provided along with competitive benefit package. Write or call: Joe Scholl, Fox Hill Associates, 250 Regency Ct, Waukesha, WI 53186; ph 414/785-6500 6/85

Full-time physician wanted for established Urgent Care center affiliated with regional hospital. Board eligibility or certification in primary specialty required. Competitive salary. 45-hours per week. Benefit package. Paid malpractice. Incentives, medium-sized city. Family-oriented progressive community. Quality school system, cultural advantages, University, abundant outside recreational opportunities. Send CV to Dept 558 in care of the Journal. p6-8/85

Internist. BC/BE to join Internal Medicine Department of multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St. Green Bay, WI 53403; ph 414/494-5611 p6-9/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

Otolaryngologist. BC/BE to join busy ENT Department within 23-member multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611. 6-9/85

Family Physician wanted to join medical clinic in small community in northwestern Wisconsin—salary or purchase agreement. Excellent recreational, educational, and hospital advantages. Send curriculum vitae to Dept 559 in care of the Journal. 6-8/85

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 4-9/85

Family Physicians, Ophthalmologist, Orthopedist needed to join 30 physicians of the Olmsted Medical Group of Rochester. Opportunities available in main office and satellites. Exceptional salary and benefit package provided in a choice professional and cultural community. Contact James E Hartfield, MD, Medical Director, 210 Ninth Street SE, Rochester, MN 55903; ph 507/288-3443. 5-7/85

$100,000 + Guarantee

Plus other incentives for approved physicians in the following specialties in mid-Michigan community—

- Obstetrician-Gynecologist
- Orthopedic Surgeon
- General Surgeon
- Family Practitioners
- ENT
- Urologist
- Pediatrician
- Internists

Contact: Vice President of Professional Services
(517) 723-5211, ext. 1823

PHYSICIANS EXCHANGE

continued

Internist with or without subspecialty interest. Board Certified or eligible, to join six other internists in a well-established, 23-man expanding multispecialty group in prosperous lakeside southeastern Wisconsin city of 36,000. The Internal Medicine Department currently has subspecialties in cardiology, pulmonary medicine, and medical oncology. Liberal fringe benefits. Initial salary plus percentage as associate. Full status in service corporation, with incentive-oriented formula after first year. Contact J F Kuglitsch, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935; ph 414/923-7420 collect. 5tfn/85

OB/GYN, and internist to join seven-doctor family practice clinic in Cloquet, Minnesota, a community of 14,000 (30,000) service area, located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped, 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally our community is noted for its excellent school system. First-year salary guarantee; paid malpractice, health, and disability insurance; vacation and study time. Contact John Turonie, Administrator, Raiter Clinic Ltd, 417 Skyline Blvd, Cloquet, Minnesota 55720. Telephone 218/879-1271. 4-6/85

Internist. BC/BE internist needed to join four internists in multispecialty group in NE Wisconsin. Competitive salary and benefits. Both subspecialty and general medicine inquiries welcome. Send CV to Neil Binkley, MD, 1510 Main St, Marinette, Wis 54143; ph 715/735-7421. 5-7/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

Wisconsin-BC/BE Pediatrician to assume an established position of a pediatrician leaving. Join a three-man pediatric department. Call or write: David L Lawrence, MD, 92 E Division St, Fond du Lac, WI 54935; ph 414/921-0560. p3-8/85

Madison, Wisconsin. Experienced physician for ambulatory care center. MedicEast, first and only independent ACC in Madison. Now well established. Located in heart of Eastside of Madison. Applicants BC/BE demonstrated experience in primary care, well-developed communication skills. Competitive salary, excellent benefits, attractive practice setting. Contact David A Goodman, MD, MedicEast, 2810 E Washington, Madison, WI 53704; ph 608/244-1213. 1tfn/85

Wanted—Qualified physician to practice emergency medicine in southeastern Wisconsin. Our group is small and flexible. Salary is negotiable. If interested, send CV to Associated Emergency Room Physicians, SC, 1131 Sherwood Lane, Caledonia, Wis 53108; ph 414/835-4489. 4-6/85

Family Physician and Internist, Pediatrician, OB/GYN, Board eligible/certified. Full or part-time, to join a busy, established group of physicians in Milwaukee. Attractive income. Send curriculum vitae to PO Box 17366, Milwaukee, WI 53217. 2-7/85

Family Practice opportunity to join a four-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1-1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, Wis 53916; ph 414/887-7101. 5tfn/85

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone: 608/263-4095 7/84;6/85

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

PHYSICIANS WANTED
Full or part-time PHYSICIANS WANTED for emergency room work throughout Wisconsin. National Emergency Services offers excellent income, paid malpractice insurance, and flexible scheduling. If you're interested in exploring opportunities with NES and you would like additional information, call James Lucas at 1-800/537-3355. 5-7/85

US Air Force Medical Corps Currently has opportunities for specialty physicians. Excellent benefits and attractive practice settings worldwide, ranging from small clinics to 1,000-bed medical centers. Positions currently available include Family Practice, Internal Medicine, Cardiology, Psychiatry, General and Orthopedic Surgery, Otorhinolaryngology, as well as Aerospace Medicine. For qualifications and more information write to 310 W Wisconsin Ave, Suite 380, Milwaukee WI 53202-2278, Attn: Capt Sealey or call 1-800/242-USAF. 5-7/85

PHYSICIANS EXCHANGE

continued

Family Practitioner. The Racine Medical Clinic, a progressive cluster corporation of 31-physicians is currently seeking a family practitioner. Full benefits, unlimited earnings, and a full and exciting practice are offered. Please contact Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 4tfn/85

Immediate opportunities for qualified physicians who possess excellent clinical and communication skills to join long-standing group of Emergency Physicians. Positions available in a popular Wisconsin area bordering Illinois. If interested, send resume to Barbara Wilczynski, Medical Emergency, Service Associates (MESA), SC, 15 S McHenry Road, Suite 2, Buffalo Grove, IL 60090 or call collect 312/459-7304. 6tfn/83

Medical Director. New position in 50-physician multispecialty clinic. To work with administrative team and professional staff, plus part-time medical practice. For more information contact James R Stormont, MD, The Monroe Clinic, Monroe, Wis 53566; ph 608/328-7000. p5-7/85

MEDICAL FACILITIES

Family Practice for sale in Milwaukee. Ideal starter or satellite office. Excellent patient goodwill. Fully equipped and furnished three examining rooms, waiting room, and office. Approximately 900 sq ft. Contact Greg Rodenbeck, DDS, 1200 E Oklahoma Ave, Milwaukee, Wis 53207; 414/481-8111. g10tfn/84

Medical equipment, examining tables, treatment tables, instrument cabinets, etc. Available in June at no cost. Retiring. Phone 414/284-2676. 5/85

Medical practice or equipment for sale in Milwaukee. Completely equipped, modern office with a modern x-ray machine. I am retiring. Please call 414/272-0250 or 414/962-9382 for an appointment. 5/85

S W Florida Island Paradise
General practice with fully-equipped medical building on 5 acres.
Sterling Intl Investments
813/337-1616
p/85

Family Practice office available in southwestern Wisconsin. Contact Dept 557 in care of the Journal. 6/85

Beaver Dam, Wisconsin. New medical office 1250 or 2500 sq ft office space available. Excellent opportunity for Dermatology or Allergy practice. Call 414/887-8887 or write PO Box 678, Beaver Dam, WI 53916. 5-8/85

MISCELLANEOUS

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LA CROSSE HEALTH AND SPORTS SCIENCE SYMPOSIUM

October 30-November 2, 1985

"Four Conferences in One" designed to provide you with the opportunity to listen, to observe, and to interact with a 64-member faculty composed of nationally renowned speakers possessing an overwhelming amount of expertise in the specialty areas of:

- Cardiac Rehabilitation
- Exercise Testing and Prescription
- Obesity and Weight Control
- Orthopaedic and Sports Injuries
- Wellness in the Hospital and Corporate Setting

In addition, pre-symposium workshops on related topics consisting of lecture and practicum are offered Tuesday pm, October 29 and Wednesday am, October 30.

For detailed information write or call: Philip K Wilson, Executive Director, La Crosse Exercise Program, 221 Mitchell Hall/UWL, La Crosse, WI 54601; ph 608-785-8686. 6/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

JULY 18–20, 1985: Wisconsin Society of Obstetrics & Gynecology, Olympia Resort, Oconomowoc. g2-6/85

JULY 25-27, 1985: 5th Annual Green Lake Conference: *Ambulatory Care.* Info: Patrick E Linton, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, WI 54923; ph 414/361-1313. g6-7/85

SEPTEMBER 6-8, 1985: Wisconsin Society of Anesthesiologists, American Club, Kohler. g5-8/85

SEPTEMBER 12-14, 1985: Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting—30th Anniversary, the Pioneer Inn, Oshkosh. Info: Wisconsin Society of Internal Medicine, 611 E Wells St, Milwaukee, Wis 53202; ph 414/276-6445. Contact: Sandra M Koehler, Executive Director. 5-8/85

SEPTEMBER 13-14, 1985: Wisconsin Neurosurgical Society, Sheraton, Racine. g5-8/85

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

SEPTEMBER 13-14, 1985: Wisconsin Surgical Society, Paper Valley Hotel & Conference Center, Appleton. g2-8/85

SEPTEMBER 20-22, 1985: Wisconsin Society of Otolaryngology—Head and Neck Surgery, Apple Valley Motel, Appleton. g6-9/85

SEPTEMBER 26, 1985: *Folk Medicine and Refugees.* The Wisconsin Center, Madison. Sponsored by Dept of Continuing Medical Education, University of Wisconsin-Madison; Wisconsin Dept of Health and Social Services, Division of Health, Bureau of Community Health and Prevention, Refugee Health Program; and School of Medicine, University of Wisconsin-Madison. AMA Category I, AAFP Prescribed, AOA Category 2-D, and University of Wisconsin CEU's—all approximately six hours. Contact: Sarah Aslakson, Dept of Continuing Medical Education, Room 465B WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 6/85

Wisconsin Specialty Society Meetings

- Wisconsin Society of Obstetrics & Gynecology, July 18-20, 1985, Olympia Resort, Oconomowoc
- Wisconsin Society of Anesthesiologists, Sept 6-8, 1985, American Club, Kohler
- Wisconsin Society of Physical Medicine & Rehabilitation, Sept 11, 1985, Sheraton Inn, Milwaukee
- Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting, Sept 12-14, 1985, Pioneer Inn, Oshkosh
- Wisconsin Surgical Society, Sept 13-14, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Neurological Society, Sept 27-28, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Society of Otolaryngology—Head and Neck Surgery, Sept 20-22, 1985, Apple Valley Motel, Appleton
- Wisconsin Dermatological Society, Oct 26, 1985, Froederdt Memorial Lutheran Hospital, Milwaukee
- Wisconsin Orthopaedic Society, Nov 1, 1985, The Olympia Resort, Oconomowoc

SEPTEMBER 27-28, 1985: Wisconsin Neurological Society, Paper Valley Hotel & Conference Center, Appleton. g5-8/85

OCTOBER 10-11, 1985: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. g5-9/85

OCTOBER 26, 1985: Wisconsin Dermatological Society, Froederdt Memorial Lutheran Hospital, Milwaukee. g6-9/85

OCTOBER 30-NOVEMBER 2, 1985: La Crosse Health and Sports Science Symposium. Info: Philip K Wilson, Executive Director, La Crosse Exercise Program, 221 Mitchell Hall/UWL, La Crosse, WI 54601; ph 608/785-8686. g6-9/85

NOVEMBER 1, 1985: Wisconsin Orthopaedic Society, The Olympia Resort, Oconomowoc. g6-10/85

AUGUST 1-3, 1985: *Practical Approaches to Managing Trauma,* Fox Hills Resort/Conference Center, Mishicot. Info: Bonnie

Fifth Annual Green Lake Conference

Ambulatory Care

Thursday-Saturday, July 25-27, 1985

The Heidel House Resort & Conference Center

Green Lake, Wisconsin

Objective: To review basic principles and recent advances in ambulatory medicine.

Program topics

- The Primary Approach to Health Maintenance
- The Evaluation of Patients with Dizziness
- The Management of Sinusitis, Otitis and Pharyngitis
- Normal Weight Control in Obesity
- Outpatient Use of Antibiotics
- Cardiac Arrhythmias—To Treat or Not to Treat
- Acute Soft Tissue Injuries (Sports Medicine)
- Arthritis—The Treatment of Inflammation
- Dysfunctional Uterine Bleeding

Credit: As an organization accredited for Continuing Medical Education, Berlin Memorial Hospital has certified this program for 12 hours of Category I. This program has applied for 12 prescribed hours by the American Academy of Family Physicians.

For more information contact: Patrick E Linton, Berlin Memorial Hospital, 225 Memorial Drive, Berlin, Wisconsin 54923; ph 414/361-1313.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

Young CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101. g6-7/85

NOVEMBER 14-16, 1985 (Minnesota): *Clinical Strategies In Primary Care Medicine,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-10/85

OTHERS

AUGUST 1-4, 1985: *Second Annual St Paul-Ramsey Trauma Conference* (Fishing & Family Recreation), Fox Hills Resort, Mishicot. Info: St Paul-Ramsey Medical Center, Continuing Medical Education, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g3/85

AUGUST 1-4, 1985 (Georgia): *International Doctors in Alcoholics Anonymous Annual Meeting.* Hyatt Regency Hotel, Savannah. Reservations may be made at a later date when specific details and instructions are published. For further information contact: Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44511; ph 216/782-6216. g12tfn/84

SEPTEMBER 9-20, 1985 (Minnesota): *Third Annual Graduate Occupational Health and Safety Institute,* Earle Brown Continuing Education Center, St Paul, MN. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-8/85

SEPTEMBER 19-21, 1985 (Minnesota): *Pulmonary and TB Update,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-8/85

OCTOBER 17-18, 1985 (Minnesota): *Toxic Chemicals in the Workplace: Health, Legal, and Regulatory Issues,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

OCTOBER 25, 1985 (Minnesota): *Promoting Healthy Lifestyles For Pregnant Women,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

OCTOBER 31-NOVEMBER 1, 1985 (Minnesota): *Latest Trends in Patient Management: Radiology and Urology,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101. g6-10/85

DECEMBER 7-11, 1985 (Florida): *12th Annual Symposium "Ear, Nose and Throat Diseases in Children: A 1985 Update,"* Palm Beach. Info: Sandra K Arjona, Dept of Pediatric Otolaryngology, Children's Hospital of Pittsburgh, 125 DeSoto St, Pittsburgh, PA 15213; ph 412/647-5466. 6,8/85

UPCOMING CME PROGRAMS SPONSORED BY ST PAUL-RAMSEY MEDICAL CENTER

Practical Approaches To Managing Trauma
Aug 1-3, 1985/Fox Hills Resort/Conference Center, Mishicot, WI

Third Annual Graduate Occupational Health and Safety Institute
Sept 9-20, 1985/Earle Brown Continuing Education Center, St Paul, MN

Pulmonary and TB Update
Sept 19-21, 1985/Radisson Plaza Hotel, St Paul, MN

Toxic Chemicals In The Workplace: Health, Legal, and Regulatory Issues
Oct 17-18, 1985/Earle Brown Continuing Education Center, St Paul, MN

Promoting Healthy Lifestyles For Pregnant Women
Oct 25, 1985/Earle Brown Continuing Education Center, St Paul, MN

Latest Trends In Patient Management: Radiology and Urology
Oct 31-Nov 1, 1985/Radisson Plaza Hotel, St Paul, MN

4th Annual Update: Clinical Strategies In Primary Care Medicine
Nov 14-16, 1985/Radisson Plaza Hotel, St Paul, MN

Coronary Heart Disease: A Comprehensive Review of Principles And Practice
Dec 5-7, 1985/Sheraton Midway Hotel, St Paul, MN

Information and registration: Bonnie Young, Continuing Medical Education, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. 6/85

AMA

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House of Bidwell 184
Knoll Pharmaceutical Co . 140, 141, 142
Isoptin®
Marion Laboratories 135, 136
Cardizem®
MedFlight 7
Medical Protective Company 10
Navy Medical Programs 184
PBBS Equipment 184
Peppino's 6
PrimeCare Health Plan of Wisconsin 9
Professionals Insurance Company, The 17
Roche Laboratories 191, 192
Dalmane®
SK&F Company 139
Dyazide®
S & L Signal Company 6
SMS Services, Inc 16
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1985 Membership Directory

(see page 17)

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CONTENTS

July 1985

SPECIAL FEATURES

President's Page

4 The urge to merge
John K Scott, MD
Madison

Editorials

5 It's confusing
Victor S Falk, MD
Edgerton

Madison medicine
Sharon R Manhart
Montrose, Colorado

Special

17 1985 Membership Directory: State Medical Society of Wisconsin

News you can use

128 Board certification increasing rapidly

Governor vetoes chiropractic coverage in budget bill

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84, No. 7

CONTENTS

STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZATIONAL

115 COUNTY MEDICAL SOCIETIES

List of Presidents and Secretaries, and other officers

118 Membership facts

121 BLUE BOOK UPDATE

Transposition of pages

Physicians Alliance Commission

Task Force on Medical Liability

Task Force on Physician Review and Discipline

DEPARTMENTS

123 MEDICAL YELLOW PAGES:

Physicians exchange

Medical facilities

Medical meetings—continuing medical education

Advertisers■

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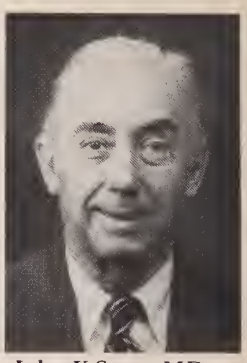
The urge to merge



John K Scott, MD

FOR SOME 20 YEARS I have been in the independent small group practice of otolaryngology in Madison. Recently, in the face of what we perceive as the competitive future of medical practice, I and my partners along with nearly 100 independents, solos, and small groups of physicians, have decided to merge our separate practices into a new group which will also form the physician core of a new HMO.

For me this is a traumatic experience; and I vow that it will not interfere with my judgment as to what is best for my patients in the way of the care I give them. Yet, I am concerned about the long-term effects of what we are doing and what others are doing on a much grandeur scale.

This urge to merge is occurring all across our land. The huge Lovelace Clinic in Albuquerque has just merged with Hospital Corporation of America. The Jackson Clinic in Madison is talking an "arrangement" with Mayo Clinic in Rochester, Minnesota. The corporatization or conglomerizing of medicine is proceeding at a rapid pace.

There are those who predict that by the year 2000 some 20 corporations will provide the medical and hospital care and insurance service for six out of every ten Americans. The estimate is that at least half of these will be for-profit operations with first loyalty to stockholders.

Is all this good for the patient?

New England Journal of Medicine editor Arnold Relman says "no." For the past five years Doctor Relman has been a kind of Paul Revere, warning his colleagues of the pitfalls of corporate medicine.

He fears the new money milieu will deny access to a large part of the population who can't afford care because "if health care is distributed by income, that's what markets do." He is repelled by the thought of physicians who involve themselves financially in medical companies as stockholders or "owner entrepreneurs."

I agree with him that you can't have good medicine "for any patient unless doctors work for their patients' interests first, last and foremost." As I said in my inaugural address, now is the time for virtue in medical practice.

It is mostly one's own conscience that stands guard over that which is good treatment and fair dealing for the patient despite the innumerable government regulations and competitive schemes we have today. The truest guardian of good patient care remains a physician with a good conscience.

Medicine is not practiced for governments, it is not practiced for insurance companies or HMOs. It is not practiced for hospitals or for that matter, doctors. Medicine is practiced for people. It embodies a skill and most of all, a desire by the doctor to prevent disease or injury in human beings. . .dedication to give each patient the opportunity to enjoy a better quality for his or her life.

When the patient reaches out for help whether in fear or insecurity or grief, he does not reach for a procedural manual. He does not reach for the bylaws of the hospital or the HMO. He reaches for his physician's hand. He must not reach in vain. Advocacy for the patient is our theme.

The patient's best hope, and our own, is that the physician's relationship with the patient be one of such commitment that it will survive whatever pressures are put upon it now or in the future by competition, market forces, or corporate and profit motives.■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

It's confusing

MADISON, OUR capital city, is sometimes irreverently called MAD city. It is also a hotbed of HMOs. A recent rash of changes there in the HMOs certainly must be confusing to the average patient.

U-Care is the HMO of the UW Medical School physicians and it dropped its affiliation with Compcare which is the HMO sponsored by Blue Cross-Blue Shield United. It then joined the Group Health Cooperative of Central Wisconsin. Then the physicians from Madison General Hospital dropped their connection with Compcare and formed a new HMO called Physician Health Plus Plan. Compcare which is based in Milwaukee had 39,000 subscribers in Madison. Wisconsin Physicians Service, based in Madison, owns a third of Physicians Plus Health Plan, another third is owned by the doctor's group, and the remaining third by Madison General Hospital. Also, the Physicians Plus Group includes 93 physicians, mostly specialists and smaller clinics in Madison, most of whom had been previously signed up with Compcare.

Prior to this affiliation, WPS had lost out when HMOs were developed in Madison about two years ago. The two largest clinics in Madison had previously formed their own HMOs. One other plan called HMO of Wisconsin was formed by physicians in smaller communities in several counties nearby.

Although this all sounds very confusing, the situation appears very clear to the various plan and clinic administrators. One was quoted saying that a "very aggressive marketing plan can be expected." Another stated "when everything is up for grabs like this, you go after the business." And a third one stated that "this was the year we were hoping to cut back on advertising expenses; fat chance!"

We have been told in recent years that medical marketing is the name of the game. Some game!

—*Victor S Falk, MD,* Edgerton

Madison medicine

The following letter is being reprinted here with permission of the author. It originally appeared in the June 1985 issue of *Madison* magazine.

* * *

My husband and I left Madison nearly two years ago after 19 years in the practice of ENT surgery (otolaryngology) with a fine group of partners. This summer his brother will leave Madison after practicing anesthesia for 17 years with Madison Anesthesiologists, Inc, the leader in the field in Madison for 25 years.

You might ask what did these two successful specialists have to fear by staying in the changing scene of Madison health care? The answer is: probably nothing, since their groups will go on without them without dropping a stitch, if you'll pardon the pun. The financial losses are greater by moving than by staying, for medicine there pays well no matter what the plan.

Then why leave? The basic reason: unhappiness. In spite of the joy of treating patients, the business of medicine in our lovely city had degraded for the practitioner in many ways, to the point where the term "unhappiness in the workplace" began to apply to this most lofty of professions.

For the first time, the spectre of competition placed the MD in the position of arguing, haranging, accusing, belittling and scheming against his/her fellow professionals. Competition has always been brisk among Madison doctors, but suddenly much of the competition was being managed by the career health marketeer. MDs, whose former idea of competition was that "the cream will rise to the top," suddenly knew that success would be measured by who had the slickest ads and who could shave the bids to give care for less while promising more.

All this meant that MDs could be jerked around through every HMO enrollment season, that large amounts of the medical service dollar would be siphoned off into advertising, that the mesmerizing of the patient pool would hold equal importance with the treating of the patient pool.

For many years, the Madison "bubble" was an insulator from the slings and arrows of big cities or the cultural gap of small towns. Now there's a realization that Madison, unlike bigger or smaller cities, is a truly captive market. Gradually that same bubble, by attracting too many MDs and having a public overbalanced by government employ, began to entrap a unique medical environment, with too many professionals fighting over easily herded public payrolls. The result is a jungle in which a daily survival battle goes on under the name of patient service.

—*Sharon R Manhart,* Montrose, Colorado

Editor's Note: President Scott's Page in this issue also addresses similar issues.■

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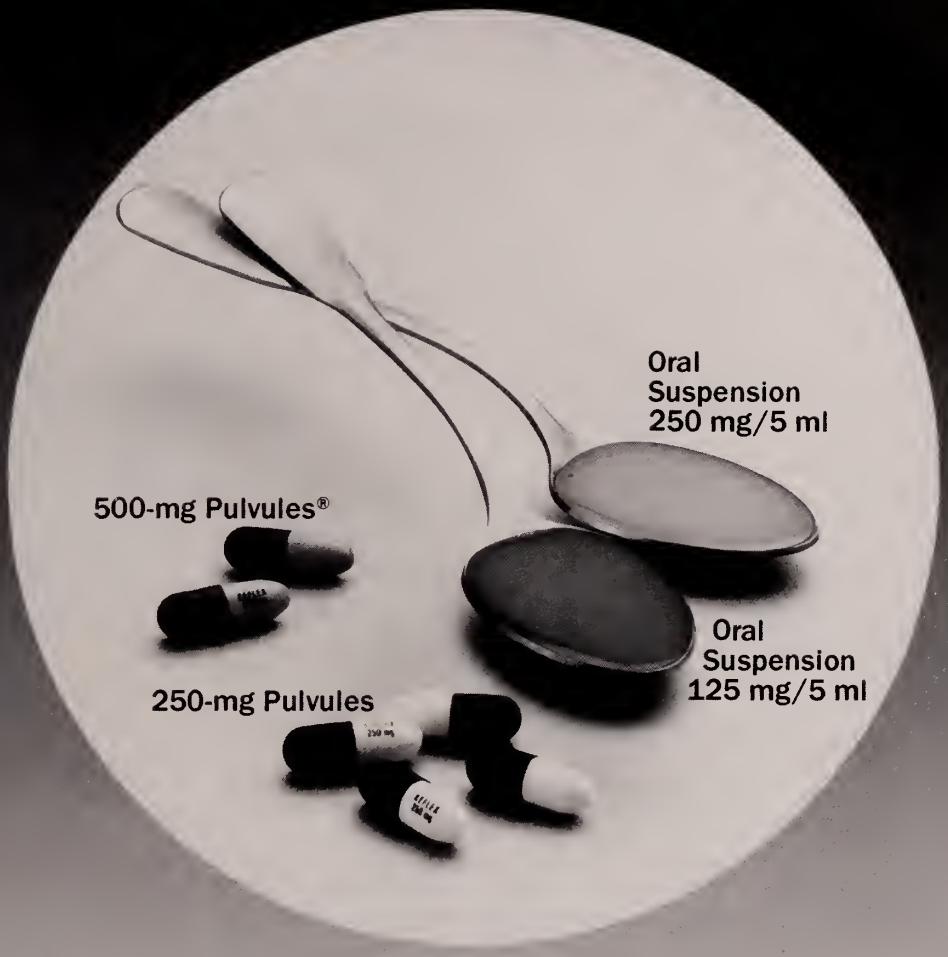

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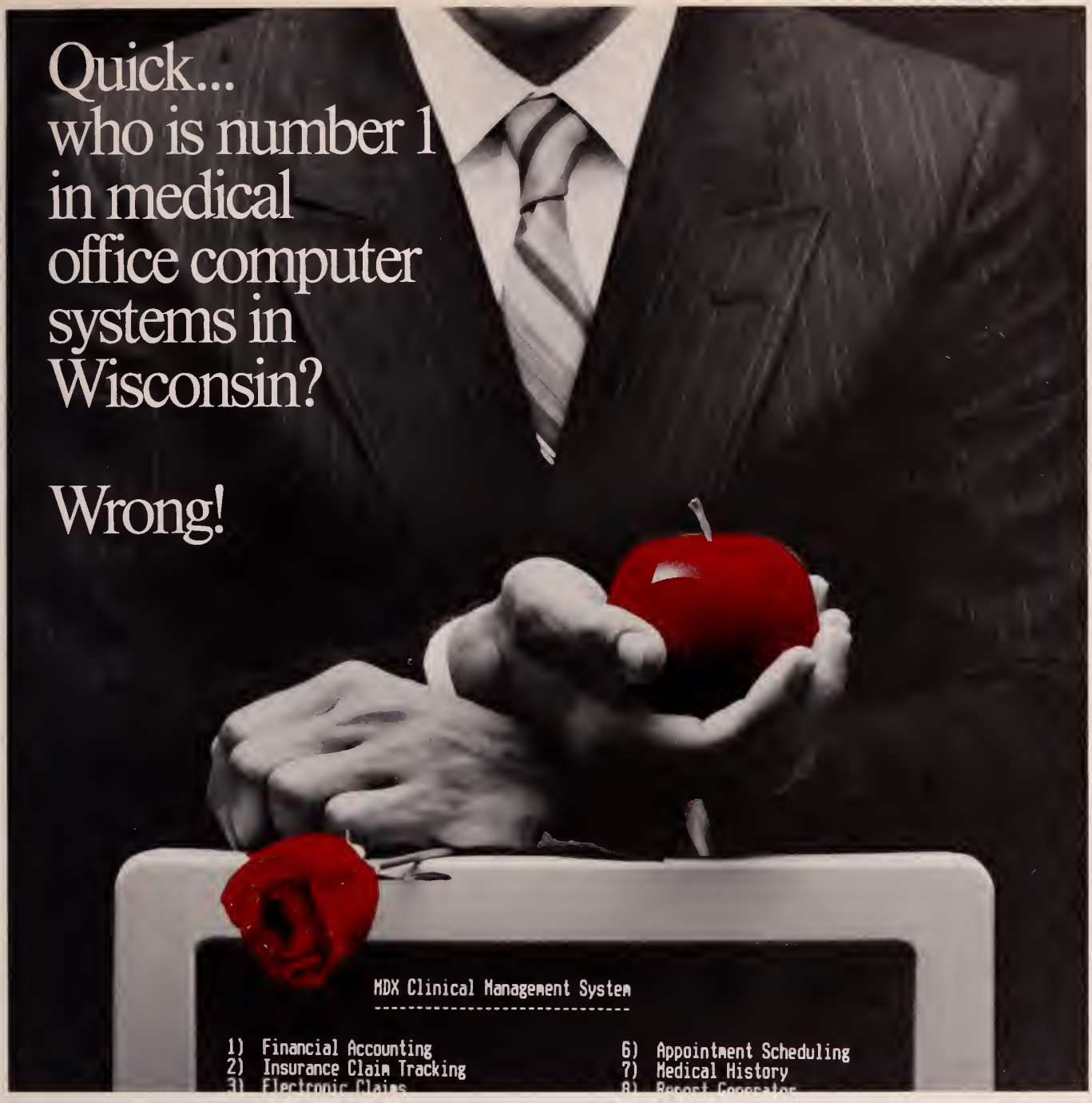

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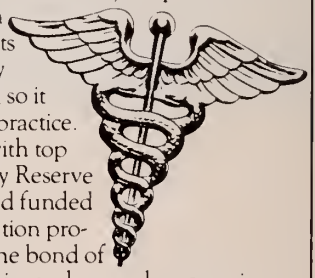

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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
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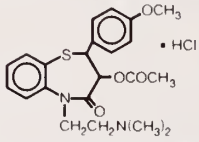
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGDT, SGPT, and LOH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LOH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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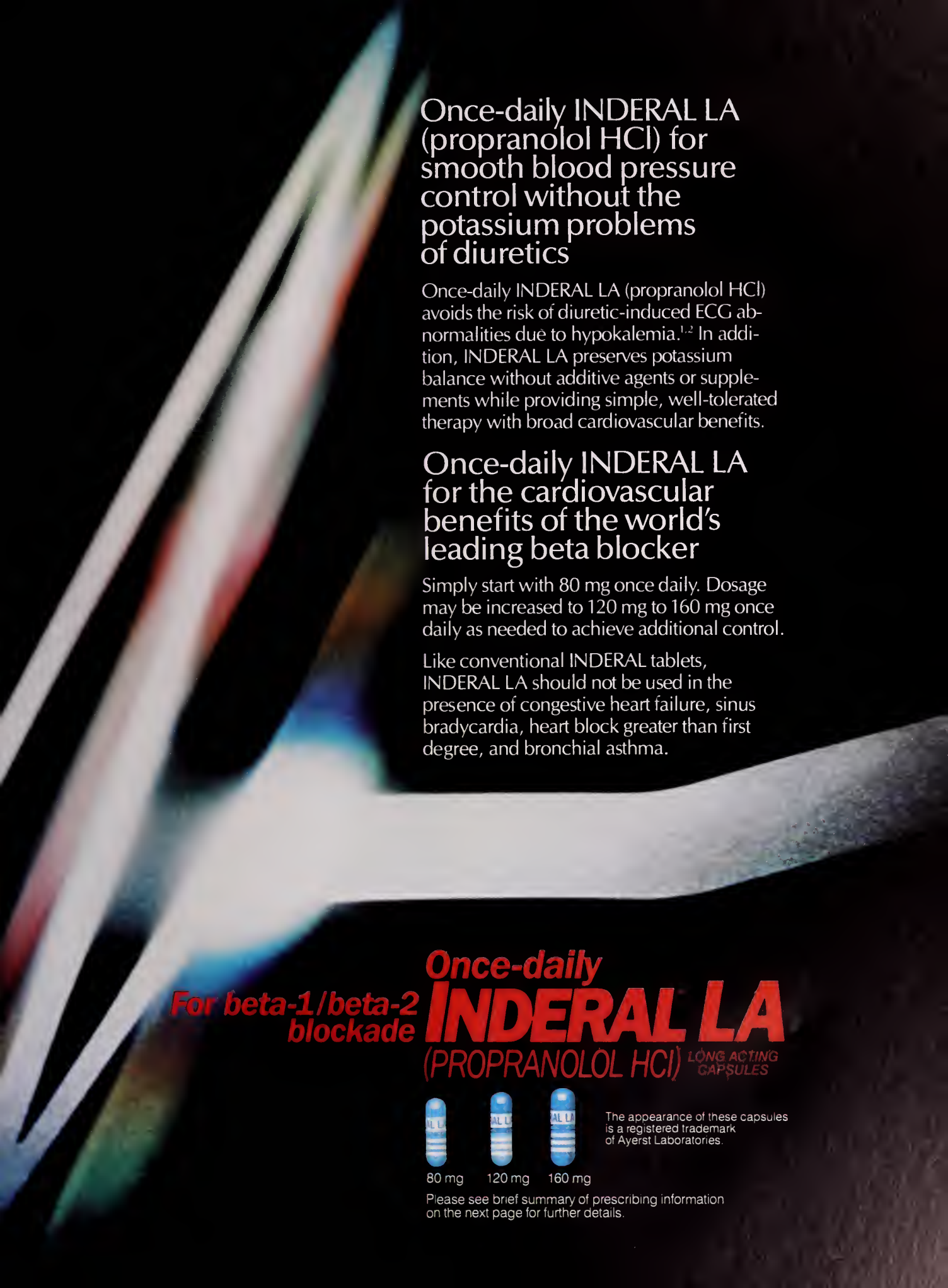
J-5491 June 1985

Right from the start in hypertension...



Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299

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1985

Membership Directory

as of July 1, 1985

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In the event of inaccuracies members are asked to contact the Membership Department for followup correction in subsequent issues of the Journal. See further explanation on following pages.

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Box 1109, Madison, Wisconsin 53701

COMPILATION INFORMATION

Information in this directory has been provided by the State Medical Society's Membership Department after each member was given the opportunity to verify its accuracy by returning a Verification Form sent to all members of record at June 3, 1985. To save time and expense this year's Directory has been produced directly from the computer printout. Another change from previous years is the elimination of the asterisk for identifying specialties in which the member is Board-certified.

This year the Membership Department has created a computer program which allows members to designate up to three specialties (primary specialty and secondary specialties) in which they practice. These specialty designations appear in the Directory on the first line of each member listing before the slash (/). Also on the first line after the slash, members are allowed to designate up to three specialties or subspecialties in which they are Board-certified.

The State Medical Society of Wisconsin recognizes the practice specialties as used by the American Medical Association in its *American Medical Directory,* which includes data collected on Board certification from physicians themselves and from the American Board of Medical Specialties, which provides information in the publication of the *Directory of Medical Specialists.* Only those certifications from the 23 Boards included in the *Directory of Medical Specialists* are included in this Membership Directory.

Practice specialties and Board certifications have been provided by individual members who returned the Verification Form or previously had provided the Membership Department with this information. In neither case has the specialty or certification designations been routinely verified with any other source. The specialty codes used in this Directory are used for record-keeping and do not imply recognition or endorsement of any field of medicine. They are intended for use in this Directory only and are not to be used for changing or updating other records. The State Medical Society of Wisconsin, its officers, agents, and employees, make no claims as to accuracy, nor accept liability for information that may not be correct, or for errors and omissions.

CORRECTION FORM

Members whose information in this Membership Directory is not accurate are urged to submit changes to the Membership Department on the form below. Such changes will be published in subsequent issues of the WMJ.

TO: Membership Department, State Medical Society of Wisconsin, PO Box 1109, Madison, Wisconsin 53701

Please correct the information used in the 1985 Membership Directory on your records as follows:

COUNTY MEDICAL SOCIETY _____

PRACTICE SPECIALTIES (use codes from page 3)

PRIMARY	SECONDARY	SECONDARY

BOARD-CERTIFIED SPECIALTIES (use codes from page 3)

TELEPHONE # _____

NAME _____

STREET _____ SUITE/APT #_____

PO BOX #_____

CITY _____ STATE _____ ZIP _____

SIGNED _____ DATE _____

AMA codes for self-designated PRACTICE SPECIALTIES (primary and secondary)

- A Allergy
- ABS Abdominal Surgery
- ADL Adolescent Medicine
- AI Allergy & Immunology
- AM Aerospace Medicine
- AN Anesthesiology
- BE Bronchoesophagology
- BLB Blood Banking
- CD Cardiovascular Diseases
- CDS Cardiovascular Surgery
- CHN Child Neurology
- CHP Child Psychiatry
- CLP Clinical Pathology
- CRS Colon & Rectal Surgery
- D Dermatology
- DIA Diabetes
- DMP Dermatopathology
- DR Diagnostic Radiology
- EM Emergency Medicine
- END Endocrinology
- FOP Forensic Pathology
- FP Family Practice
- GE Gastroenterology
- GER Geriatrics
- GP General Practice
- GPM General Preventive Medicine
- GS General Surgery
- GYN Gynecology
- HEM Hematology
- HNS Head & Neck Surgery
- HS Hand Surgery
- HYP Hypnosis
- ID Infectious Diseases
- IG Immunology
- IM Internal Medicine
- LAR Laryngology
- LM Legal Medicine
- MFS Maxillofacial Surgery
- N Neurology
- NA Neuropathology
- ND Neoplastic Diseases
- NEP Nephrology
- NM Nuclear Medicine
- NPM Neonatal-perinatal Medicine
- NR Nuclear Radiology
- NS Neurological Surgery
- NTR Nutrition
- OBG Obstetrics & Gynecology
- OBS Obstetrics
- OM Occupational Medicine
- ON Oncology
- OPH Ophthalmology
- ORS Orthopaedic Surgery
- OS Other; *ie*, physician designated a specialty other than appearing here
- OT Otology
- OTO Otorhinolaryngology
- P Psychiatry
- PA Clinical Pharmacology
- PD Pediatrics
- PDA Pediatric Allergy
- PDC Pediatric Cardiology
- PDE Pediatric Endocrinology
- PDR Pediatric Radiology
- PDS Pediatric Surgery
- PH Public Health
- PHO Pediatric-Hematology-Oncology
- PM Physical Medicine & Rehabilitation
- PNP Pediatric Nephrology
- PS Plastic Surgery
- PTH Pathology
- PUD Pulmonary Diseases
- PYA Psychoanalysis
- PYM Psychosomatic Medicine
- R Radiology
- RHI Rhinology
- RHU Rheumatology
- RIP Radioisotopic Radiology
- TR Therapeutic Radiology
- TRS Traumatic Surgery
- TS Thoracic Surgery
- U Urological Surgery

BOARD CERTIFICATIONS

- **AI American Board of Allergy & Immunology**
  - AI Allergy & Immunology
- **AN American Board of Anesthesiology**
  - AN Anesthesiology
  - CCM Critical Care Medicine
- **CRS American Board of Colon & Rectal Surgery**
  - CRS Colon & Rectal Surgery
  - ARS Anorectal Surgery
- **D American Board of Dermatology**
  - D Dermatology
  - DMP Dermatopathology
- **EM American Board of Emergency Medicine**
  - EM Emergency Medicine
- **FP American Board of Family Practice**
  - FP Family Practice
- **IM American Board of Internal Medicine**
  - IM Internal Medicine
  - AI Allergy & Immunology
  - CD Cardiovascular Disease
  - CCM Critical Care Medicine
  - END Endocrinology & Metabolism
  - GE Gastroenterology
  - HEM Hematology
  - ID Infectious Disease
  - MON Medical Oncology
  - NEP Nephrology
  - PUD Pulmonary Disease
  - RHU Rheumatology
- **NS American Board of Neurological Surgery**
  - NS Neurological Surgery
- **NM American Board of Nuclear Medicine**
  - NM Nuclear Medicine
- **OBG American Board of Obstetrics & Gynecology**
  - OBG Obstetrics & Gynecology
  - OBS Obstetrics
  - GYN Gynecology
  - CCM Critical Care Medicine
  - GON Gynecologic Oncology
  - MFM Maternal & Fetal Medicine
  - RE Reproductive Endocrinology
- **OPH American Board of Ophthalmology**
  - OPH Ophthalmology
- **ORS American Board of Orthopaedic Surgery**
  - ORS Orthopaedic Surgery
  - AOS Adult Orthopaedic Surgery
- **OTO American Board of Otolaryngology**
  - OTO Otolaryngology
- **PTH American Board of Pathology**
  - PTH Clinical Pathology & Pathologic Anatomy
  - BLB Blood Banking
  - CP Chemical Pathology
  - CLC Clinical Chemistry
  - CLP Clinical Pathology
  - DMP Dermatopathology
  - FOP Forensic Pathology
  - HEM Hematology
  - MC Medical Chemistry
  - MMB Medical Microbiology
  - NA Neuropathology
  - PA Pathologic Anatomy
  - RP Radioisotopic Pathology
- **PD American Board of Pediatrics**
  - PD Pediatrics
  - CCM Critical Care Medicine
  - NPM Neonatal-Perinatal Medicine
  - PDA Pediatric Allergy
  - PDC Pediatric Cardiology
  - PDE Pediatric Endocrinology
  - PHO Pediatric Hematology-Oncology
  - PNP Pediatric Nephrology
- **PS American Board of Plastic Surgery**
  - PS Plastic Surgery
- **PM American Board of Physical Medicine & Rehabilitation**
  - PM Physical Medicine & Rehabilitation
- **PN American Board of Psychiatry & Neurology**
  - PN Psychiatry & Neurology
  - P Psychiatry
  - N Neurology
  - CHP Child Psychiatry
  - CHN Child Neurology
  - CCM Critical Care Medicine
- **GPM American Board of Preventive Medicine**
  - AM Aerospace Medicine
  - GPM General Preventive Medicine
  - OM Occupational Medicine
  - PH Public Health
- **R American Board of Radiology**
  - R Radiology
  - DR Diagnostic Radiology
  - TR Therapeutic Radiology
  - DNR Diagnostic-Nuclear Radiology
- **GS American Board of Surgery**
  - GS General Surgery
  - GVS General Vascular Surgery
  - PDS Pediatric Surgery
  - CCM Critical Care Medicine
- **TS American Board of Thoracic Surgery**
  - TS Thoracic Surgery
- **U American Board of Urology**
  - U Urology

Key to CITIES in COUNTY MEDICAL SOCIETIES

City — *County Medical Society / ies*

Adell—Sheboygan
Algoma—Door/Kewaunee
Alma—Trempealeau/Jackson/Buffalo
Altoona—Eau Claire/Dunn/Pepin
Amery—Polk
Aniwa—Langlade
Antigo—Langlade
Appleton—Outagamie, Winnebago
Arcadia—Trempealeau/Jackson/Buffalo
Arena—Milwaukee
Arkansaw—Pierce/St Croix
Ashland—Ashland/Bayfield/Iron

Baldwin—Pierce/St Croix
Baraboo—Sauk
Barron—Barron/Washburn/Burnett
Bayfield—Ashland/Bayfield/Iron
Bayside—Milwaukee
Beaver Dam—Dodge, Jefferson
Belgium—Ozaukee
Belleville—Dane
Beloit—Rock
Berlin—Green Lake/Waushara
Big Bend—Waukesha
Black Earth—Dane
Black River Falls—Trempealeau/Jackson/Buffalo
Blanchardville—Lafayette
Bloomer—Chippewa
Bonduel—Shawano
Boscobel—Grant
Boyd—Chippewa
Brillion—Calumet
Brodhead—Green
Brookfield—Milwaukee, Waukesha
Brooklyn—Green, Dane
Brown Deer—Milwaukee
Brownsville—Fond du Lac
Bruce—Rusk
Burlington—Kenosha, Milwaukee, Racine
Butte Des Morts—Winnebago

Cadott—Chippewa
Caledonia—Racine
Cambridge—Jefferson
Cameron—Barron/Washburn/Burnett
Campbellsport—Fond du Lac
Cassville—Grant
Cedarburg—Ozaukee, Milwaukee, Washington
Cedar Grove—Jefferson
Centuria—Dane
Chetek—Barron/Washburn/Burnett
Chilton—Calumet
Chippewa Falls—Chippewa
Clam Lake—Dane
Clear Lake—Polk
Clintonville—Waupaca
Colby—Clark
Columbus—Columbia/Marquette/Adams, Dodge
Cornell—Chippewa
Cottage Grove—Dane
Crandon—Forest, Wood
Crivitz—Marinette/Florence
Cross Plains—Dane

City — *County Medical Society / ies*

Cuba City—Grant
Cudahy—Milwaukee
Cumberland—Barron/Washburn/Burnett

Darlington—Lafayette
Deerbrook—Langlade
Deerfield—Dane
De Forest—Dane
Delafield—Milwaukee, Waukesha
Delavan—Walworth
Denmark—Brown
DePere—Brown, Oconto
DeSoto—Trempealeau/Jackson/Buffalo
Dodgeville—Iowa
Dousman—Waukesha
Durand—Eau Claire/Dunn/Pepin, Trempealeau/Buffalo/Jackson

Eagle—Milwaukee
Eagle River—Oneida/Vilas
East Ellsworth—Pierce/St Croix
East Troy—Walworth, Milwaukee
Eau Claire—Eau Claire/Dunn/Pepin, Chippewa
Edgar—Marathon
Edgerton—Rock
Eleva—Eau Claire/Dunn/Pepin
Elkhart Lake—Sheboygan, Milwaukee
Elkhorn—Walworth
Ellsworth—Pierce/St Croix
Elm Grove—Milwaukee, Waukesha
Elmwood—Pierce/St Croix
Elroy—Juneau
Evansville—Rock

Fall Creek—Eau Claire/Dunn/Pepin
Fitchburg—Dane
Fond du Lac—Fond du Lac
Fontana—Walworth
Fort Atkinson—Jefferson
Fox Point—Milwaukee, Waukesha
Franklin—Milwaukee, Racine
Franksville—Racine, Kenosha
Frederic—Polk
Fredonia—Ozaukee, Dodge
Friendship—Columbia/Marquette/Adams

Galesville—Trempealeau/Jackson/Buffalo
Genesee Depot—Waukesha
Germantown—Waukesha, Milwaukee
Gillett—Oconto, Fond du Lac, Oneida/Vilas
Glendale—Milwaukee
Glenwood City—Pierce/St Croix
Gordon—Douglas
Grafton—Ozaukee, Milwaukee
Grantsburg—Barron/Washburn/Burnett
Green Bay—Brown
Greendale—Milwaukee
Greenfield—Marathon
Green Lake—Green Lake
Greenwood—Clark
Greshem—Shawano

City — *County Medical Society / ies*

Hales Corners—Milwaukee
Hartford—Washington
Hartland—Milwaukee, Waukesha
Hayward—Sawyer
Hazel Green—Grant
Hilbert—Calumet
Hollandale—Iowa
Holmen—La Crosse
Horicon—Dodge
Hortonville—Outagamie
Hudson—Pierce/St Croix
Hurley—Ashland/Bayfield/Iron

Iola—Waupaca

Jackson—Washington
Janesville—Rock
Jefferson—Jefferson
Jim Falls—Chippewa
Juneau—Dodge

Kaukauna—Outagamie
Kenosha—Kenosha
Kewaskum—Washington
Kewaunee—Door/Kewaunee
Kiel—Sheboygan
Kimberly—Outagamie
King—Waupaca
Kohler—Sheboygan

La Crosse—La Crosse
Lac du Flambeau—Oneida/Vilas, Wood
Ladysmith—Rusk
La Farge—Vernon
Lake Geneva—Walworth
Lake Mills—Jefferson
Lake Tomahawk—Oneida/Vilas, Marathon
Lancaster—Grant
Land O'Lakes—Oneida/Vilas
Laona—Forest
Larsen—Winnebago
Little Chute—Outagamie
Lodi—Columbia/Marquette/Adams, Dane, Sauk
Loyal—Clark
Luxemburg—Brown

Madison—Dane
Manawa—Waupaca
Manitowoc—Manitowoc
Marathon—Marathon
Markesan—Dodge
Marinette—Marinette/Florence
Marion—Waupaca
Marshfield—Wood
Mauston—Juneau
Mayville—Dodge, Milwaukee
Mazomanie—Dane
McFarland—Dane
Medford—Price/Taylor
Menasha—Outagamie, Winnebago
Menomonee Falls—Washington, Waukesha Milwaukee
Menomonie—Eau Claire/Dunn/Pepin
Mequon—Milwaukee, Ozaukee, Waukesha
Merrill—Lincoln

City *County Medical Society / ies*

Middleton—Dane, Sauk
Milton—Rock
Milwaukee—Milwaukee, Ozaukee, Washington, Waukesha, Racine
Mineral Point—Iowa
Minocqua—Oneida/Vilas
Mishicot—Manitowoc
Mondovi—Trempealeau/Jackson/Buffalo, Eau Claire/Dunn/Pepin
Monona—Dane
Monroe—Green
Montfort—Iowa
Monticello—Green
Montello—Columbia/Marquette/Adams
Mosinee—Marathon
Mt Calvary—Fond du Lac
Mt Horeb—Dane
Mukwonago—Milwaukee, Waukesha
Muscoda—Grant
Muskego—Waukesha, Milwaukee

Nashotah—Waukesha, Milwaukee
Neenah—Outagamie, Winnebago
Neillsville—Clark
Nekoosa—Wood
New Berlin—Waukesha, Milwaukee
New Glarus—Green
New Holstein—Calumet
New Lisbon—Juneau
New London—Waupaca
New Richmond—Pierce/St Croix

Oconomowoc—Milwaukee, Waukesha
Oconto—Marinette/Florence, Oconto
Oconto Falls—Oconto, Brown
Ogema—Price/Taylor
Omro—Winnebago
Onalaska—Dodge, La Crosse
Oneida—Brown
Oostburg—Sheboygan, Milwaukee
Oregon—Dane
Orfordville—Rock
Osceola—Polk
Oshkosh—Winnebago, Fond du Lac
Osseo—Eau Claire/Dunn/Pepin
Owen—Clark
Oxford—Columbia/Marquette/Adams

City *County Medical Society / ies*

Paddock Lake—Dodge
Park Falls—Price/Taylor
Peshtigo—Marinette/Florence
Pewaukee—Waukesha, Milwaukee
Phillips—Price/Taylor
Plain—Sauk
Platteville—Grant
Plover—Portage
Plum City—Pierce/St Croix
Plymouth—Sheboygan
Portage—Columbia/Marquette/Adams
Port Washington—Ozaukee, Milwaukee
Pound—Marinette/Florence
Poynette—Dane
Prairie du Chien—Crawford
Prairie du Sac—Sauk
Prescott—Pierce/St Croix
Pulaski—Brown

Racine—Racine, Kenosha
Random Lake—Sheboygan
Reedsburg—Sauk, Monroe
Rhinelander—Oneida/Vilas
Rice Lake—Barron/Washburn/Burnett
Richfield—Washington
Richland Center—Richland
Ripon—Fond du Lac
River Falls—Pierce/St Croix
River Hills—Milwaukee, Waukesha
Rosholt—Portage
Rothschild—Marathon

St Croix Falls—Polk
Schofield—Marathon
Shawano—Shawano, Oneida/Vilas
Sheboygan—Sheboygan
Sheboygan Falls—Sheboygan
Shell Lake—Barron/Washburn/Burnett
Shorewood—Milwaukee
Sister Bay—Door/Kewaunee
Slinger—Washington
Soldiers Grove—Trempealeau/Jackson/Buffalo
South Milwaukee—Milwaukee
Sparta—Monroe
Spooner—Barron/Washburn/Burnett
Spring Green—Sauk
Spring Valley—Pierce/St Croix
Stanley—Chippewa
Stevens Point—Portage
Stoughton—Jefferson, Dane
Sturgeon Bay—Door/Kewaunee
Sun Prairie—Dane
Superior—Douglas

City *County Medical Society / ies*

Theresa—Dodge
Thiensville—Ozaukee, Milwaukee
Tigerton—Shawano
Tomahawk—Lincoln, Marathon
Three Lakes—Milwaukee
Tomah—Monroe
Two Rivers—Manitowoc, Kenosha
Turtle Lake—Barron/Washburn/Burnett

Union Grove—Racine

Valders—Manitowoc
Verona—Dane
Viroqua—Vernon, Trempealeau/Jackson/Buffalo

Walworth—Walworth
Washburn—Ashland/Bayfield/Iron
Waterloo—Jefferson
Watertown—Jefferson
Waukesha—Waukesha, Milwaukee
Waupaca—Waupaca, Outagamie
Waupun—Dodge, Fond du Lac
Wausau—Marathon
Wausaukee—Marinette/Florence
Wautoma—Winnebago
Wauwatosa—Milwaukee, Waukesha, Ozaukee, Washington
West Allis—Milwaukee
West Bend—Washington, Walworth
Westby—Vernon, Trempealeau/Jackson/Buffalo
Westfield—Green Lake, Milwaukee
West Salem—La Crosse
Weyauwega—Waupaca
Whitefish Bay—Milwaukee
Whitehall—Trempealeau/Jackson/Buffalo
Whitewater—Walworth, Jefferson
Wild Rose—Green Lake/Waushara
Wind Lake—Kenosha, Milwaukee
Winnebago—Winnebago
Winneconne—Winnebago
Wisconsin Dells—Columbia/Marquette/Adams, Sauk
Wisconsin Rapids—Wood
Withee—Clark
Wonewoc—Juneau
Wood—Milwaukee
Woodruff—Marathon, Oneida/Vilas■

THE STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841 . . . representing over 5,100 member physicians in Wisconsin, comprising 55 county medical societies and 25 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socio-economics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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BAYFIELD WI 54814

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2101 BEASER AVENUE
ASHLAND WI 54806

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PAUL VAN PERNIS MD
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ASHLAND WI 54806

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ASHLAND WI 54806

AN IM
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ASHLAND WI 54806

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CHETEK WI 54728

FP / FP
715-463-5317
MARK R BIXBY MD
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GRANTSBURG WI 54840

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JOEL A BORMANN DO
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CUMBERLAND WI 54829

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LAWRENCE D CARLSON MD
1020 LAKESHORE DRIVE
RICE LAKE WI 54868

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715-234-9031
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S—Dennis J Kontra, MD
5802 Washington Avenue
Racine, WI 53406
T—Kenneth J Pechman, MD
2405 Northwestern Avenue
Racine, WI 53404
ES—Mr John M Bjelajac
PO Box 592
Racine, WI 53401
(414) 634-0702

RICHLAND
P—Thomas L Richardson, MD
1313 West Seminary Street
Richland Center, WI 53581
(608) 647-6161
S—Robert P Smith, MD
1313 West Seminary Street
Richland Center, WI 53581
(608) 647-6161

ROCK
P—Jovan L Djokovic, MD
630 Wexford Drive
Janesville, WI 53545
S—Daniel T Peterson, MD
580 North Washington Street
Janesville, WI 53545
(608) 755-3500

RUSK
P—Joseph S Bachir, MD
906 College Avenue West
Ladysmith, WI 54848
(715) 532-6651
S—Ron M Charipar, MD
1216 East River
Ladysmith, WI 54848
(715) 532-5561

SAUK
P—David E Burnett, MD
1900 North Dewey Avenue
Reedsburg, WI 53959
S—James W Clay, MD
1900 North Dewey Avenue
Reedsburg, WI 53959

SAWYER
P—Lloyd M Baertsch, MD
Rte 3, Box 3998
Hayward, WI 54843
S—Paul Strapon III, MD
Rte 3, Box 3998
Hayward, WI 54843

SHAWANO
P—William A Coan, MD
610 West Green Bay Street
Shawano, WI 54166
(715) 526-3137

S—Alois J Sebesta, MD
126½ South Main Street
PO Box 360
Shawano, WI 54166
(715) 526-3313

SHEBOYGAN
P—Robert A Helminiak, MD
1011 North 8th Street
Sheboygan, WI 53081

S—Robert J Scott, MD
2809 North 7th Street
Sheboygan, WI 53081
(414) 457-5033

TREMPEALEAU-JACKSON-BUFFALO
P—John H Noble, MD
1105 Harrison Street
Black River Falls, WI 54615

S—James J Dickman II, MD
610 West Adams Street
Black River Falls, WI 54615
(715) 284-4311

VERNON
P—David A Van Dyke, MD
PO Box 149
Viroqua, WI 54665
(608) 637-7052

VP—Thomas M Ambelang, MD
PO Box 467
Viroqua, WI 54665

S—Deverne W Vig, MD
PO Box 72
Viroqua, WI 54665
(608) 637-3195

WALWORTH
P—James L Knavel, MD
PO Box B
Ten Peller Road
Lake Geneva, WI 53147
(414) 248-4467

S—James V Seegers, MD
104 South Wisconsin Street
Elkhorn, WI 53121
(414) 723-6666

WASHINGTON
P—James D Froehlich, MD
7066 North Trenton Road
West Bend, WI 53095
(414) 673-5745

S—Emilio B Regala, MD
1004 East Sumner Street
Hartford, WI 53027
(414) 673-5745

WAUKESHA
P—Thomas J Dougherty, MD
1111 Delafield Street
Waukesha, WI 53186
(414) 542-9531

S—Robert L Warth, MD
1111 Delafield Street
Waukesha, WI 53186
(414) 544-4411

T—Gerald L Harned, MD
223 Wisconsin Avenue
Waukesha, WI 53186
(414) 544-5311

ES—Mr Robert Herzog
850 Elm Grove Road, #1
Elm Grove, WI 53122
(414) 784-3747

WAUPACA
P—Leslie H Gray, MD
46 North Main Street
Clintonville, WI 54929

S—Donn D Fuhrmann, MD
1420 Algoma Street
New London, WI 54961
(414) 982-3606

WINNEBAGO
P—John B McAndrew, MD
600 S Main St
Oshkosh, WI 54901
414/233-1773

S—Roy E Buck, MD
PO Box 165
Oshkosh, WI 54902
(414) 233-6000

WOOD
P—Richard H Ulmer, MD
1000 North Oak Avenue
Marshfield, WI 54449

S—Michael J Kryda, MD
1000 North Oak Avenue
Marshfield, WI 54449
(715) 387-5319■

Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1985 are $455 for SMS, $330 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin
DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Your membership in organized medicine will help insure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1985 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1985 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455	$330	Normal County Dues
Resident	45.50	45	Varies
Military Service	-0-	220 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	227.50	330*	Normal County Dues
Over Age 70	227.50	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	20	Varies
Sophomore and Succeeding Medical Student Years	10	20	Varies
Postgraduate—One	10	45	Varies

*Physicians in the following categories may be eligible for exemption from paying AMA dues: (1) Financial hardship and/or disability, (2) Age 65-69 and retired from the practice of medicine, (3) Over age 70 *regardless* of retirement status.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

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Transposition of pages

In the June BLUE BOOK issue, under Commissions and Committees, pages 123 and 124 were inadvertently transposed.

Also in this same issue the Physicians Alliance Commission, recently merged as indicated on page 124 (corrected to page 123), is as follows:

Physicians Alliance Commission

This Commission shall plan, organize, and implement programs to protect and preserve the legislative, socioeconomic, and political interests of the members of the State Medical Society of Wisconsin. The Commission shall analyze state and federal legislation and administrative rules and policies, and recommend to the Board of Directors specific actions and positions designed to carry out this responsibility. The Commission shall also inform the membership of the Society regarding proposed legislation and other public policy initiatives, seek the enactment of legislation for the best interests of the public, scientific medicine, and the medical profession, and promote and encourage Society members to be politically active individually and collectively. This Commission shall act to protect the socioeconomic interests of the Society membership in public and private health care delivery systems and recommend to the Board of Directors specific strategies and efforts to achieve this purpose. This Commission shall consist of members appointed by the Board of Directors in a number deemed sufficient to execute the responsibilities delegated to the Commission. Membership on the Commission shall also include a representative from each of the specialty sections of the Society, subject to approval by the Board of Directors. These representatives shall be appointed by the sections annually, and shall have the right to vote on all matters before the Commission. The President, President-elect, Immediate Past President, and Chairman of the Board of the Society shall serve as ex-officio members of the Commission with vote.

Robert F Purtell Jr, MD, Milwaukee, Chairman, 1986
Charles E Pechous, MD, Kenosha, Vice Chairman, 1986
Joseph C DiRaimondo, MD, Manitowoc, 1987
Vernon Dodson, MD, Madison, 1987
Carl S L Eisenberg, MD, Milwaukee, 1986
Jordon Frank, MD, Beloit, 1986
Gerald A Gehl, MD, Neenah, 1987
Ronald L Harms, MD, Shawano, 1987
C Robert Jackson, MD, Madison, 1987
H Myron Kauffman, MD, Wauwatosa, 1987
Geoffrey C Kloster, MD, Merrill, 1988
Dennis J Kontra, MD, Racine, 1987
Jack M Lockhart, MD, La Crosse, 1986
Michael P Mehr, MD, Marshfield, 1986
John C Oujiri, MD, Ashland, 1988
Peter J Parthum, MD, MPH, Muskego, 1988
Michael C Reineck, MD, West Bend, 1988
John O Simenstad, MD, Osceola, 1988
Charles L Steidinger, MD, Platteville, 1988
Joseph L Teresi, MD, Brookfield, 1988
John E Thompson, MD, Nekoosa, 1988
W Gregory Von Roenn, MD, Milwaukee, 1986
DeLore Williams, MD, West Allis, 1987
Raymond C Zastrow, MD, Milwaukee, 1986

EX OFFICIO VOTING MEMBERS:
President: *John K Scott, MD,* Madison
President-elect: *Charles W Landis, MD,* Milwaukee
Immediate Past President: *Timothy T Flaherty, MD,* Neenah
Chairman of the Board: *Darold A Treffert, MD,* Fond du Lac

continued next column

SECTION REPRESENTATIVES:
Anesthesiology Section: *John F Kreul, MD,* Madison
Family Physicians Section: *Terry L Hankey, MD,* Wausau
Internal Medicine Section: *Susan L Turney, MD,* Marshfield
Ophthalmology Section: *M Thomas Chemotti, MD,* Cedarburg
Otolaryngology Section: *William W Finch, MD,* Madison
Pathology Section: *Harry J Zemel, MD,* Fond du Lac
Pediatrics Section: *Ferrin C Holmes, MD,* Sturgeon Bay
Radiology Section: *George F Roggensack, MD,* Madison

(Other Section Representatives to be appointed)

* * *

Two newly created task forces, to follow the commissions and committees (pages 122-125) are:

Task Force on Medical Liability

The purpose of this task force shall be to monitor current liability developments and to examine a series of options and alternatives relative to a long-range solution of the medical liability problem, reporting to the Board of Directors.

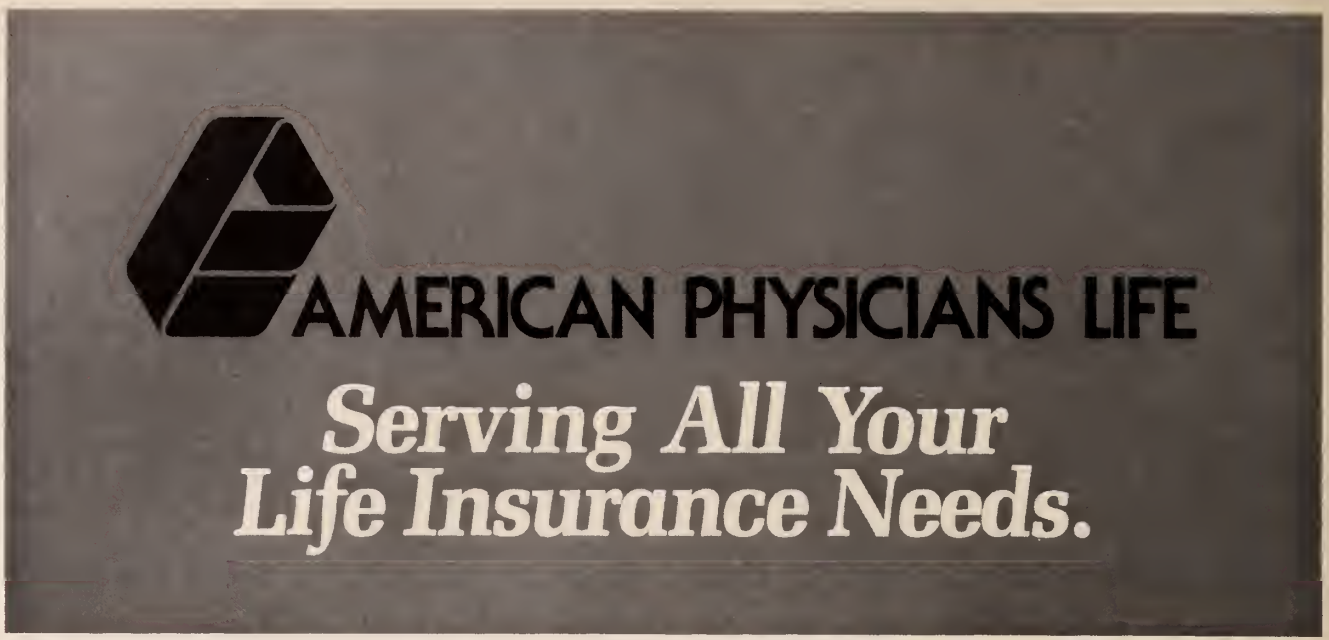
William J Listwan, MD, West Bend, Chairman
Vaughn Demergian, MD, Madison
Jerome W Fons Jr, MD, Cudahy
C Robert Jackson, MD, Madison
Paul A Jacobs, MD, Milwaukee
Sidney E Johnson, MD, Marshfield
Thomas M Kidder, MD, Milwaukee
Frederick C Kriss, MD, Madison
Walter D Moritz, MD, Fort Atkinson
Russell A Quirk, MD, Racine
Michael C Reineck, MD, West Bend
Richard G Roberts, MD, Darlington
Paul H Steingraeber, MD, La Crosse
W Stuart Sykes, BM, Madison
William L Treacy, MD, Milwaukee
Robert F Purtell Jr, MD, Milwaukee
Kenneth M Viste Jr, MD, Oshkosh

(Members to be added from certain specialties)

Task Force on Physician Review and Discipline

The purpose of this task force shall be to evaluate and make recommendations for the improvement of physician review and discipline in the State of Wisconsin. Its findings and recommendations shall be made to the Board of Directors as they are developed, and a final report to the Board and the House should be available no later than March 1, 1986.

Peter L Eichman, MD, Madison, Chairman
C William Freeby, MD, Appleton
Richard D Fritz, MD, Milwaukee
Lucille B Glicklich, MD, Milwaukee
Cyril M Hetsko, MD, Madison
John J Kief, MD, Rhinelander
Timothy T Flaherty, MD, Neenah
William L Treacy, MD, Milwaukee
Russell F Lewis, MD, Marshfield
Gerald C Kempthorne, MD, Spring Green
Robert E Johnston, MD, Green Bay
Charles S Geiger, MD, West Bend
D Mark Lochner, MD, Waupaca
George F Flynn, MD, Milwaukee
William L Baker, MD, Monroe
Adolf L Gundersen, MD, La Crosse
Rudolf W Link, MD, Madison
Edwin L Overholt, MD, La Crosse
Philip H Utz, MD, La Crosse
Barry Blackwell, MD, Milwaukee■



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CONTACT:

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MADISON, WISCONSIN 53701
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PHYSICIANS EXCHANGE

Family Practitioner. Marshfield Clinic Department of Family Medicine is seeking a BE/BC Family Practitioner for a new position. The physician joining the Clinic's expanding 5-member department will enjoy the support of one of the nation's largest multispecialty groups, share the philosophy of family-oriented care with a preventive focus, and enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Marshfield Clinic offers an excellent salary plus extensive fringe benefits. Please send curriculum vitae and the names of several references to: E Grady Mills, MD, Family Medicine Department Chairman, Marshfield Clinic, Marshfield, WI 54449 or call collect at 715/387-5168. p6-8/85

Primary care physician. Dodge Correctional Institution, Waupun, Wisconsin—Bureau of Correctional Health Services, Division of Health. $23.80 per hour plus add-on depending on experience or training. Starting pay is currently being reviewed and may be adjusted after July. Physician with background in general or family practice *or* internal medicine sought for a part-time position (50%) with Department of Health and Social Services at Dodge Correctional Institution (DCI). DCI is the male reception center for the state prison system. The physician will be engaged in coordinating the assessment and evaluation of medical needs for new prisoners, providing direct medical care in an ambulatory setting, and supervising the Physician Assistant. Inquiries should be made to Barbara J Whitmore, Box 309, Madison, Wisconsin 53701; tel: 608/267-7170. Equal Opportunity Employer. 7/85

Family Practice physician MD or DO Board eligible or certified. Contact Leon Gilman, 4957 West Fond du Lac Ave, Milwaukee, WI 53216 or call 414/871-7900. 6-8/85

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; e.g., copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

West Bend, Wisconsin, General Clinic, a (18) physician multispecialty group, is seeking physicians in the specialties of Internal Medicine, Family Practice, OB/GYN, and Pediatrics. First-year salary guaranteed. Corporate membership possible after one year. Excellent fringe benefits. Located in scenic, recreational area with close proximity to Milwaukee. Please contact Hans W Schmelzling, Administrator, General Clinic, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 6tfn/85

Versatile Surgeon wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E Johnson, Ely Medical Center, Ltd, 224 East Chapman Street, Ely, Mn 55731; ph 218/365-3151. 6tfn/85

Psychiatrist. Full-time adult staff position in well-established HMO serving over 210,000 people in one of the leading metropolitan areas of the Midwest. Join excellent staff of 35 psychotherapists and seven psychiatrists. Outstanding benefits, competitive salaries and a flexible work week providing time for teaching and other professional pursuits. Send curriculum vitae to: Paul J Brat, MD, Medical Director, Group Health, Inc, 2829 University Avenue Southeast, Minneapolis, Minnesota 55414. 6-7/85

Attractive opportunity for a Board certified/eligible family physician to establish a new community practice. The family practitioner will be eligible for full-hospital privileges at Beloit Memorial Hospital, a medium-sized acute care facility. This opportunity offers a guaranteed financial and start-up package. Inquiries or CV should be directed to Gregory K Britton, Administrative Director, Beloit Memorial Hospital, 1969 West Hart Road, Beloit, Wisconsin 53511; ph 608/364-5104. p6-8;g9/85

Excellent opportunity for a Board certified or eligible internist to practice in conjunction with an 8-member Internal Medicine Department of a 26-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 6tfn/85

Family Practice. Third Family Practice physician needed to join multispecialty group of 17 in Hartford, WI. Two branch locations. All facilities modern and well equipped. Guaranteed first year negotiable salary; usual fringe benefits. Contact: Murlin Bernd, Clinic Manager, 1004 E Sumner St, Hartford, WI 53027; ph 414/673-5745 p7-8/85

Internal Medicine. Hospital-based private practice; rural community near Eau Claire, Wisconsin; part-time satellite available. Call sharing and guarantees provided. Critical care management. Two hours to Minneapolis. Charles Nelson, Fox Hill Associates, 250 Regency Ct, Waukesha, WI 53186; ph 414/785-6500. p7/85

Internist to join satellite of multispecialty clinic in Madison, Wisconsin. Satellite is located ten miles from Madison and has one internist already practicing. Support from all departments anticipated from multispecialty clinic. Fringe benefits and salary attractive plus excellent working conditions, environment and associates. New satellite is growing and additional physician is needed to give our patients quality care. Send resume to Dept 556 in care of the Journal. p6-8/85

Obstetrician/Gynecologist, Board eligible/certified, for Green Bay metropolitan area. Large multispecialty clinic with excellent salary and benefits. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611 p6-9/85

Internist-Infectious Disease Physician. The Racine Medical Clinic, a progressive cluster corporation of 32 physicians, is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 6tfn/85

Full-time physician wanted for established Urgent Care center affiliated with regional hospital. Board eligibility or certification in primary specialty required. Competitive salary. 45-hours per week. Benefit package. Paid malpractice. Incentives, medium-sized city. Family-oriented progressive community. Quality school system, cultural advantages, University, abundant outside recreational opportunities. Send CV to Dept 558 in care of the Journal. p6-8/85

PHYSICIANS EXCHANGE

continued

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 4-9/85

Family Physicians, Ophthalmologist, Orthopedist needed to join 30 physicians of the Olmsted Medical Group of Rochester. Opportunities available in main office and satellites. Exceptional salary and benefit package provided in a choice professional and cultural community. Contact James E Hartfield, MD, Medical Director, 210 Ninth Street SE, Rochester, MN 55903; ph 507/288-3443. 5-7/85

Internist. BC/BE to join Internal Medicine Department of multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St. Green Bay, WI 53403; ph 414/494-5611 p6-9/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone 608/263-4095 7/85-6/86

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

Otolaryngologist. BC/BE to join busy ENT Department within 23-member multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611. 6-9/85

Family Practice physician needed to join five family practitioners and a general surgeon. Immediate opportunity in west central Wisconsin near La Crosse. $45,000 first year guarantee plus incentive. Excellent recreational area. Community hospital. Send CV to William L Simpson, Administrator, PO Box 250, Sparta, WI 54656; or phone 608/269-6731. p5-7/85

Madison, Wisconsin. Experienced physician for ambulatory care center. Medic-East, first and only independent ACC in Madison. Now well established. Located in heart of Eastside of Madison. Applicants BC/BE demonstrated experience in primary care, well-developed communication skills. Competitive salary, excellent benefits, attractive practice setting. Contact David A Goodman, MD, Medic-East, 2810 E Washington, Madison, WI 53704; ph 608/244-1213. 1tfn/85

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

MD positions nationwide. No fee. **Advanced Medical Placements, Inc.** 6414 Copps Avenue, Madison, WI 53716. Tel: 608/222-5556. p7/85

Walk-In Clinic Physician. Position available July 1. Regular hours, no call, no inpatient responsibilities, guaranteed salary, generous benefits. Prefer generalist physician comfortable with urgent care situation. Part of 50 physician multispecialty group in beautiful La Crosse, WI; population 50,000. If interested, please call or write P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, WI 54601; ph 608/782-9760. 7/85

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

Internist with or without subspecialty interest. Board Certified or eligible, to join six other internists in a well-established, 23-man expanding multispecialty group in prosperous lakeside southeastern Wisconsin city of 36,000. The Internal Medicine Department currently has subspecialties in cardiology, pulmonary medicine, and medical oncology. Liberal fringe benefits. Initial salary plus percentage as associate. Full status in service corporation, with incentive-oriented formula after first year. Contact J F Kuglitsch, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935; ph 414/923-7420 collect. 5tfn/85

Family Practice opportunity to join a four-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1-1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, Wis 53916; ph 414/887-7101. 5tfn/85

US Air Force Medical Corps Currently has opportunities for specialty physicians. Excellent benefits and attractive practice settings worldwide, ranging from small clinics to 1,000-bed medical centers. Positions currently available include Family Practice, Internal Medicine, Cardiology, Psychiatry, General and Orthopedic Surgery, Otorhinolaryngology, as well as Aerospace Medicine. For qualifications and more information write to 310 W Wisconsin Ave, Suite 380, Milwaukee WI 53202-2278, Attn: Capt Sealey or call 1-800/242-USAF. 5-7/85

PHYSICIANS EXCHANGE

continued

Family Practitioner. The Racine Medical Clinic, a progressive cluster corporation of 31-physicians is currently seeking a family practitioner. Full benefits, unlimited earnings, and a full and exciting practice are offered. Please contact Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 4tfn/85

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Medical Director. New position in 50-physician multispecialty clinic. To work with administrative team and professional staff, plus part-time medical practice. For more information contact James R Stormont, MD, The Monroe Clinic, Monroe, Wis 53566; ph 608/328-7000. p5-7/85

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Family Physician and Internist, Pediatrician, OB/GYN, Board eligible/certified. Full or part-time, to join a busy, established group of physicians in Milwaukee. Attractive income. Send curriculum vitae to PO Box 17366, Milwaukee, WI 53217. 2-7/85

Wisconsin-BC/BE Pediatrician to assume an established position of a pediatrician leaving. Join a three-man pediatric department. Call or write: David L Lawrence, MD, 92 E Division St, Fond du Lac, WI 54935; ph 414/921-0560. p3-8/85

Internist. BC/BE internist needed to join four internists in multispecialty group in NE Wisconsin. Competitive salary and benefits. Both subspecialty and general medicine inquiries welcome. Send CV to Neil Binkley, MD, 1510 Main St, Marinette, Wis 54143; ph 715/735-7421. 5-7/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

OB/GYN, and internist to join seven-doctor family practice clinic in Cloquet, Minnesota, a community of 14,000 (30,000) service area, located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped, 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally our community is noted for its excellent school system. First-year salary guarantee; paid malpractice, health, and disability insurance; vacation and study time. Contact John Turonie, Administrator, Raiter Clinic Ltd, 417 Skyline Blvd, Cloquet, Minnesota 55720. Telephone 218/879-1271. 7-9/85

MEDICAL FACILITIES

Beaver Dam, Wisconsin. New medical office 1250 or 2500 sq ft office space available. Excellent opportunity for Dermatology or Allergy practice. Call 414/887-8887 or write PO Box 678, Beaver Dam, WI 53916. 5-8/85

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MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

SEPTEMBER 6-8, 1985: Wisconsin Society of Anesthesiologists, American Club, Kohler. g5-8/85

SEPTEMBER 12-14, 1985: Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting—30th Anniversary, the Pioneer Inn, Oshkosh. Info: Wisconsin Society of Internal Medicine, 611 E Wells St, Milwaukee, Wis 53202; ph 414/276-6445. Contact: Sandra M Koehler, Executive Director. 5-8/85

SEPTEMBER 13-14, 1985: Wisconsin Neurosurgical Society, Sheraton, Racine. g5-8/85

SEPTEMBER 13-14, 1985: Wisconsin Surgical Society, Paper Valley Hotel & Conference Center, Appleton. g2-8/85

SEPTEMBER 20-22, 1985: Wisconsin Society of Otolaryngology—Head and Neck Surgery, Apple Valley Motel, Appleton. g6-9/85

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

SEPTEMBER 18-20, 1985: *"10th Annual Nuclear Cardiology Symposium,"* presented by Cardiovascular Disease Program, Milwaukee Clinical Campus, School of Medicine, University of Wisconsin Continuing Medical Education. Red Carpet Hotel, Milwaukee. AMA Category I, UW Extension CEUs and VOICE credit. Contact: Sarah Aslakson; University of Wisconsin-Extension; Continuing Medical Education; Room 465B WARF Bldg; 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 7/85

SEPTEMBER 20-21, 1985: *Multiple Sclerosis Conference.* The Concourse Hotel, Madison. Sponsored by Department of Neurology, School of Medicine, University of Wisconsin; and Department of Continuing Medical Education, University of Wisconsin-Extension. AMA Category I, University of Wisconsin-Extension CEUs, AAFP prescribed credit, and AOA Category 2-D credit. Contact: Sarah Aslakson, University of Wisconsin-Extension, Continuing Medical Education, Room 465B WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 7/85

Wisconsin Specialty Society Meetings

- Wisconsin Society of Anesthesiologists, Sept 6-8, 1985, American Club, Kohler
- Wisconsin Society of Physical Medicine & Rehabilitation, Sept 11, 1985, Sheraton Inn, Milwaukee
- Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting, Sept 12-14, 1985, Pioneer Inn, Oshkosh
- Wisconsin Surgical Society, Sept 13-14, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Neurological Society, Sept 27-28, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Society of Otolaryngology—Head and Neck Surgery, Sept 20-22, 1985, Apple Valley Motel, Appleton
- Wisconsin Dermatological Society, Oct 26, 1985, Froederdt Memorial Lutheran Hospital, Milwaukee
- Wisconsin Orthopaedic Society, Nov 1, 1985, The Olympia Resort, Oconomowoc

SEPTEMBER 20-21, 1985: *The Coronary Care Unit Conference.* The Wisconsin Center, Madison. Sponsored by Department of Continuing Medical Education, University of Wisconsin-Extension; and Department of Medicine, School of Medicine, University of Wisconsin. AMA Category I, University of Wisconsin-Extension CEUs and AAFP prescribed credit. Contact: Sarah Aslakson, University of Wisconsin-Extension, Continuing Medical Education, Room 465B WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 7/85

SEPTEMBER 27-28, 1985: Wisconsin Neurological Society, Paper Valley Hotel & Conference Center, Appleton. g5-8/85

OCTOBER 4, 1985: *Practical Aspects of Vascular Disease.* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin Medical School, Departments of Family Medicine and Practice, Radiology, Surgery, and Continuing Medical Education, in cooperation with University of Wisconsin Hospital and Clinics. AMA Category I, AAFP, AOA Category 2-D, and University of Wisconsin CEUs—all 7 hours. Contact: Sarah Aslakson, Department of Continuing Medical Education, 610 Walnut St, Room 465B, Madison, WI 53705; ph 608/263-2856. 7/85

OCTOBER 10-11, 1985: Fall Symposium of Wisconsin Chapter: American College of Emergency physicians & Emergency Department Nurses Association. The Abbey, Fontana. g7-9/85

SECOND ANNUAL CITIZENS' CONFERENCE ON ALCOHOL AND DRUG RELATED PROBLEMS: BRIDGING RELATIONSHIPS
September 26, 1985 / Mead Inn Wisconsin Rapids
Keynote Speaker: John K MacIver, Attorney, Milwaukee
Workshop topics:

- AODA and the Criminal Justice System
- Community Organization and Advocacy
- Drug Abuse Treatment Trends
- Legislation
- Fetal Alcohol Syndrome
- Intoxicated Driver Program
- Innovative Prevention/Intervention Approaches
- AODA and Health

Info: Arlene Meyer, State Medical Society; 1-800/362-9080 or 608/257-6781. g7-8/85

OCTOBER 10-11, 1985: *Update in Allergy and Clinical Immunology II.* The Inn-Tower Hotel, Madison. Sponsored by Department of Continuing Medical Education and Department of Medicine, School of Medicine, University of Wisconsin-Madison. AMA Category I, University of Wisconsin CEUs. Family Practice credit has been applied for. Approximately 11 hours. Info: Ann Bailey, Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2854. 7-9/85

OCTOBER 11-12, 1985: *Eating Disorders.* The Westowner, Madison. Sponsored by Department of Continuing Medical Education, University of Wisconsin-Madison; Eating Disorders Program, University of Wisconsin Hospital; and Department of Pediatrics, University of Wisconsin-Madison. AMA Category I, AAFP, AOA Category 2-D, ADA pending, WNA pending, and University of Wisconsin CEUs—all 10 hours. Contact: Sarah Aslakson, Department of Continuing Medical Education, Room 465B, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 7/85

OCTOBER 18-19, 1985: *Focus on Rheumatology—1985.* University of Wisconsin Clinical Science Center, Madison. Sponsored by Department of Medicine, School of Medicine, University of Wisconsin; and Department of Continuing Medical Education, University of Wisconsin, in cooperation with University of Wisconsin Hospital and Clinics. AMA Category I, AAFP, AOA Category 2-D, and University of Wisconsin CEUs—all 8½ hours. Contact: Sarah Aslakson, Department of Continuing Medical Education, 610 Walnut St, Room 465B WARF Bldg, Madison, WI 53705; ph 608/263-2856. 7/85

OCTOBER 26, 1985: Wisconsin Dermatological Society, Froederdt Memorial Lutheran Hospital, Milwaukee. g6-9/85

JANUARY 25—FEBRUARY 1, 1986: *Sports Medicine Cruise Seminar,* SS Constitution, Hawaiian Islands. Sponsored by University of Wisconsin School of Medicine, Continuing Medical Education. AMA Category I credit 16 hours, Family Practice credit pending, and 16 hours University of Wisconsin CEUs. Contact: Ann Bailey, Department of Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison WI 53705; ph 608/263-2854. 7-9/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

OTHERS

SEPTEMBER 9-20, 1985 (Minnesota): *Third Annual Graduate Occupational Health and Safety Institute,* Earle Brown Continuing Education Center, St Paul, MN. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-8/85

SEPTEMBER 19-21, 1985 (Minnesota): *Pulmonary and TB Update,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-8/85

OCTOBER 3-4, 1985 (New York): *8th Annual Current Concerns in Adolescent Medicine—"A Practitioners Guide to Teenage Health Care,"* The Warwick Hotel, New York City. Sponsored by: Division of Adolescent Medicine, Department of Pediatrics, Schneider Children's Hospital, Long Island Jewish Medical Center, New Hyde Park, New York. Credits: 13 Category 1 from ACCME and AMA. Info: Ann J Boehme, Associate Director for Continuing Education, Long Island Jewish Medical Center, New Hyde Park, New York 11042; ph 718/470-8650. p7/85

OCTOBER 17-18, 1985 (Minnesota): *Toxic Chemicals in the Workplace: Health, Legal, and Regulatory Issues,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

OCTOBER 25, 1985 (Minnesota): *Promoting Healthy Lifestyles For Pregnant Women,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

OCTOBER 31-NOVEMBER 1, 1985 (Minnesota): *Latest Trends in Patient Management: Radiology and Urology,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101. g6-10/85

OCTOBER 30-NOVEMBER 2, 1985: La Crosse Health and Sports Science Symposium. Info: Philip K Wilson, Executive Director, La Crosse Exercise Program, 221 Mitchell Hall/UWL, La Crosse, WI 54601; ph 608/785-8686. g6-9/85

NOVEMBER 1, 1985: Wisconsin Orthopaedic Society, The Olympia Resort, Oconomowoc. g6-10/85

NOVEMBER 14-16, 1985 (Minnesota): *Clinical Strategies In Primary Care Medicine,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-10/85

DECEMBER 5-7, 1985 (Minnesota): *Coronary Heart Disease: A Comprehensive Review of Principles and Practice,* Sheraton Midway Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-11/85

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1986–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the La Crosse Convention Center.

1986—April 17–19
1987—March 26–28
1988—April 28–30
1989—April 13–15
1990—April 26–28
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

AMA

DECEMBER 8–11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

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Inderal® LA
Centralized Billing Systems 120
Dista Products Co (Div of Eli Lilly & Co) 7
Keflex®
House of Bidwell 114
Marion Laboratories 11, 12
Cardizem®
Medical Protective Company 8
PBBS Equipment 114
Peppino's 117
Professionals Insurance Company, The 119
Roche Laboratories ..... 129, BC
Dalmane®
S & L Signal Company 10
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BOARD CERTIFICATION INCREASING RAPIDLY. Despite its voluntary nature board certification has been increasing rapidly, AMA research economist Steven Culler, PhD and sociologist Edmund R Becker, PhD said in an article published in the January issue of the *Journal of Medical Education.* Between 1971 and 1981 the annual growth rate of physicians obtaining board certification was 7.2%, while the annual increase in all physicians was 3.2%. By the end of 1981, 53.2% of US physicians were board-certified. The percentage is higher (62.2%) if only nonfederal patient care physicians are considered. If the growth rate of the 1970s and early 1980s continues through 1989, nearly 70.4% of all physicians will be board-certified by the end of the decade. By the turn of the century 90% will be. The AMA Center for Health Policy Research found that the board certification was more prevalent for certain specialties, ages, types of practice, and locations of practice. Surgical and medical specialists, for example, were the most likely to be board-certified (74.4% and 65.2%, respectively), while general practitioners were the least likely to be (39.9%). Although board-certified physicians had higher gross incomes on the average than their nonboard-certified counterparts, they also appeared to have higher overheads that dissipated the economic advantage of board certification. Finally, comparisons of the hours worked per week and weeks worked per year show only small differences between board-certified and nonboard-certified physicians.

The authors also point out that an important aspect of a physicians's career, the decision to obtain specialty board certification, is voluntary and does not appear to provide physicians with additional legal privileges in the practice of medicine. Moreover physicians are not required to limit themselves to the practice specialty in which they are certified. The certification boards are in no sense educational institutions, and the certificate of a board is not to be considered a degree (ref: *'82-'83 Directory of Residency Training Programs.* Chicago, Illinois: American Medical Association, 1982). In short, the authors emphasize that board certification does not confer on any person legal qualifications or privileges, nor does it in any way interfere with or limit the professional activities of a licensed physician. To become board-certified in a specialty, a physician needs to complete the required graduate training and pass the board-certification examination. In spite of the fact that board certification does not enhance a physician's legal qualifications, there are several reasons why a physician may be willing to fulfill the requirements to become board-certified, they say. One major reason is that board certification may improve the possibilities for him to acquire admitting privileges to the hospitals of his choice. In addition, he may use board certification to help gain referrals. Finally, the board-certified physician is usually viewed by patients as having successfully completed certain additional requirements beyond those required for license.■

GOVERNOR VETOES CHIROPRACTIC COVERAGE IN BUDGET BILL. On July 17 Governor Earl signed into law the 1985-87 biennial budget, but vetoed mandatory chiropractic insurance coverage which would have allowed for 28 visits per year to a chiropractor if an insurance policy included coverage of any diagnostic or treatment services or procedure by a licensed physician or osteopath. The mandated coverage would have been applicable to HMOs, PPOs, and any plan offered to state employes. Under current law, s. 628.33, chiropractic coverage must be offered by all insurance companies offering accident and health coverage to any purchasers who request it. This allows consumers the freedom of choice regarding what type of coverage they feel is necessary.

The Governor, in vetoing the sections on mandatory chiropractic coverage, stated that such coverage "erodes cost containment efforts of health insurers and results in higher priced policies and/or a reduction in other services currently being covered under the plans. Many of the cost savings realized are a result of the primary physician acting as a gatekeeper. This gatekeeper role functions as a control on excessive utilization of costly services. Mandated chiropractic coverage erodes this gatekeeper function of the primary physician and therefore, directly contributes to higher costs. In addition, mandated insurance benefits create incentives for employers to self-insure. Most large employers in the state already self-insure health benefits for their employes, and are thus exempt from any mandated coverage of chiropractic care. The Office of the Commissioner of Insurance estimates that more than 40 percent of the employes in the state are covered under self-insured plans. Therefore, the mandated coverage for chiropractic care will strongly affect the employes of smaller firms, the elderly and the individual policyholder. These are the groups that may be least able to afford the increased costs of health care," the Governor stated.

The State Medical Society, as well as several legislators, formally requested such a veto.■

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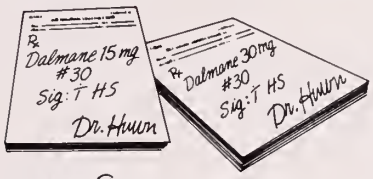

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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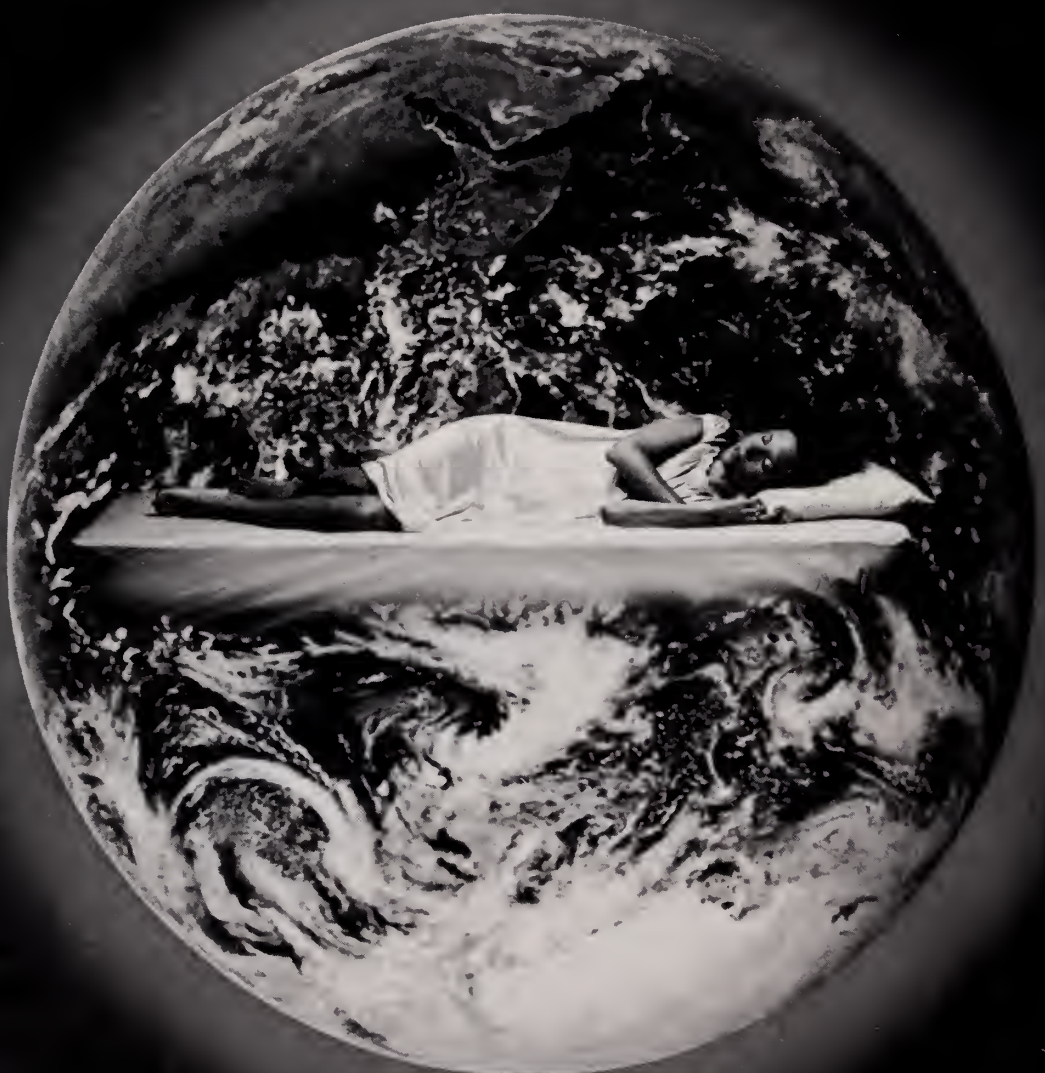

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Official Publication of the State Medical Society of Wisconsin

WISCONSIN MEDICAL JOURNAL

V.84, no.8

Bone scan changes in a marathon runner

Case report of a 34-year old marathon runner with degenerative changes in his left knee. Bone scans were done prior to and after a recent marathon during a symptomatic period. A 10% increase of osteoblastic activity in the symptomatic knee and a 3% increase in the asymptomatic knee were found. Patients with subjective and objective findings prior to a marathon should be advised to reevaluate their intense running goals. *(See page 11)*

Silo-filler's disease

The various oxides of nitrogen are produced by the fermentation process in dairy silos. These irritative toxic gases can produce a clinical spectrum ranging from immediate asphyxiation to delayed respiratory distress and with subsequent permanent lung damage. A case is reviewed and measures to prevent this tragic occurrence are described. *(See page 13)*

Neisseria meningitidis serogroup Z as a cause of meningitis

A case of Neisseria meningitidis *serogroup Z meningitis in a 19-year-old male is presented. The patient was successfully treated with aq. Penicillin-G. This is the first case of serogroup Z meningitis in a young adult in the United States.* *(See page 16)*

AUGUST 1985

M. D. COLLEGE OF PHYSICIANS OF PHILADELPHIA
SEP 17 1985

WISCONSIN MEDICAL JOURNAL

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CONTENTS

August 1985

SPECIAL FEATURES

President's Page

5 Maximum care at minimum cost
John K Scott, MD, Madison

Editorials

6 What next?
Victor S Falk, MD, Edgerton

Skulduggery in the Senate
Victor S Falk, MD, Edgerton

7 —"that made Milwaukee famous"
Victor S Falk, MD, Edgerton

Special

26 Blue Book Update

26 AMA Physician's Recognition Award recipients

Public Health

27 Statewide network set up for AIDS testing

News you can use

50 Senate Rural Health Caucus formed

HMO update

SCIENTIFIC MEDICINE

11 Bone scan changes in a marathon runner; case report
Gary N Guten, MD and *Don Craviotto, BS,* Milwaukee

12 ABSTRACT: Splenic phagocytic function after partial splenectomy and splenic autotransplantation
Mark A Malangoni, MD, et al Louisville, Kentucky and Milwaukee

13 Silo-filler's disease; a historical perspective and report of a case
William J Maurer, MD Marshfield

16 *Neisseria meningitidis* serogroup Z as a cause of meningitis
LeeAnne Nazer, MD and *Michael W Rytel, MD,* Milwaukee

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Vol. 84 No. 8

CONTENTS

STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZATIONAL

23 SMS June 29 Board Meeting results
Physicians honored
Medicare changes due October 1

24 Museum receives grant
Citizens' Conference on AODA scheduled
Financial planning seminar set, October
Fund fee assessments due

25 Doctor Pomainville honored at Medical Museum

32 CES FOUNDATION: Contributions—May 1985

35 OBITUARIES
Rodney P Gwinn, MD, Sturgeon Bay
Michael F Ries, MD, Brownsville
Rudolph P Gingrass, DDS, MD, Oconomowoc
Desmond H Callaghan, MD, Hayward
Donald D Frawley, MD, Sun City, Arizona (Milwaukee)
Rodney B Fruth, MD, Elm Grove
William E Bargholtz, MD, Ashland
Bruno J Peters, MD, Wauwatosa
Maurice H McCaffrey, MD, Dunedin, Florida (Madison)
Paul E Rutledge, MD, Washington Island
John Kimberly Curtis, MD, Madison

38 Membership facts

DEPARTMENTS

29 PHYSICIAN BRIEFS

33 COUNTY SOCIETIES: Milwaukee . . . Outagamie . . . Winnebago

34 SPECIALTY SOCIETIES: Wisconsin Academy of Family Physicians . . . American Society of Surgery of the Hand . . . Society of Thoracic Radiology . . . American Academy of Dermatology . . . American College of Utilization Review Physicians . . . American College of Physicians . . . Wisconsin Chapter, American College of Surgeons

45 MEDICAL YELLOW PAGES
Physicians exchange
Medical facilities
Miscellaneous
Medical Meetings—Continuing Medical Education
Advertisers
Books received■

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5700 member physicians in Wisconsin, comprising 55 county medical societies and 27 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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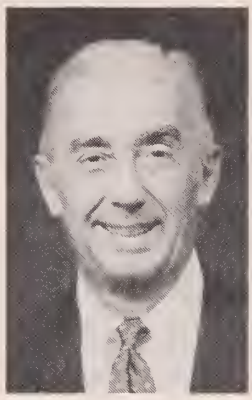

John K Scott, MD

QUESTIONS: At what point does maximum care at minimum cost affect patient care? Society is now looking at ways to help the physician control costs. Is fraud and abuse being perpetrated on the public by medicine? What is the price of the fear and apprehension that the patient develops in certain acute care situations limited by DRGs and the preadmission review program for Medicaid and Medicare?

The most recent WiPRO *Reviewer* informs us of changes in the WiPRO preadmission review (PAR) program for Medicare and Medicaid recipients. These changes went into effect July 1, 1985.

WiPRO's original PAR program was negotiated in good faith and had been accepted by the Health Care Financing Administration (HCFA) as part of WiPRO's medical review contract. It is now viewed by HCFA to be out of compliance with law and regulation. This is because the original approach to PAR was to issue an *advisory* finding made by a nurse when a case was found to not meet criteria for admission. In such cases HCFA now requires a *binding* PAR denial to be issued by a WiPRO physician advisor, "PA."

In changing from advisory to binding PAR, any case that does not meet physician-developed admissions screening criteria will be referred to a physician advisor. If the advisor finds that a case lacks medical necessity for admission, a binding denial notice must be issued and the beneficiary, practitioner, hospital, and fiscal intermediary must be promptly notified. This binding denial means that no payment would be made to the hospital if the patient were admitted with the same condition and treatment plan as described in the PAR.

The beneficiary, practitioner, and hospital then have an opportunity to request a reconsideration. WiPRO's program requires all elective admissions to be reviewed on a preadmission basis. The concern of the State Medical Society is: Who is making the judgment call for admission and care of the patient? Again, my question is: At what point does the maximum care at minimum cost affect patient care?

There are many ways to treat different illnesses. In part this is because physicians are "clones" of their residency background. But in no way are physicians perpetrating fraud and abuse on the public in attempts, often mandated by regulation, to provide only the minimum medically necessary care and thus control costs. A major question remains: What happens to the doctor/patient relationship?

What about an elderly patient, falling, injuring her hip, seen in the emergency room at night by the attending physician? The examination and x-ray films reveal no apparent fracture of the hip. The patient is subsequently taken home and treated as an outpatient. The x-ray findings in the AM reveal a fracture and the patient is readmitted 12 hours later for further care. The admission is retrospectively denied and there is a considerable amount of "hassle" between the PA reviewer, the physician, hospital, and patient as to payment.

There are entirely too many of these examples threatening good doctor/patient care. Fear and apprehension are not components of a good doctor/patient relationship.

The State Medical Society, through its Physicians Alliance Commission, is seeking evidence from physicians or patients which relates to untoward circumstances or adverse effects that have occurred as a consequence of DRGs, PRO, insurance plan rules, or other attempts to minimize cost while maximizing care. And let's remember that if these systems produce good results, the Society should hear about those, too.

In summary, please let the SMS know of your critique of the PAR program and similar efforts in Wisconsin. We all know that regulation has come upon the healthcare scene, but let's also be sure we do everything to make certain the patient is treated fairly.■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

What Next?

WE MUST CALL WiPRO to obtain permission to hospitalize a Medicare patient. Should there be a later question about this, we must also attempt to call a reviewer within a limited number of days.

We must get a second opinion before performing certain surgical procedures on Medicaid patients and patients covered by certain insurance companies. The rather strange thing about these second opinions for Medicaid is that should the second opiner indicate that the procedure is not necessary in his opinion, the patient may still opt to have the surgery performed.

As indicated in a recent editorial, we must call Detroit to obtain permission to hospitalize employees of a particular industry as well as any of the employees' dependents. Should the hospitalization extend beyond the very limited number of days initially granted, it is necessary to call Detroit again for the extension. Also if it is necessary to transfer the patient to a more sophisticated facility for some specialized care, it is again necessary to call Mo-Town. Recently some clinics have been billing the industry for the time spent on these telephone calls. Thus far there has been no recompense—but the physicians feel better for having expressed their aggravation.

Some of us are strongly advised by WiPRO that we must decrease our Medicaid patient admissions by an arbitrary 20 percent. We also are told that we must cut down on the number of complications following cholecystectomies.

HMOs tell us that there is an overrun on laboratory work when it is done outside a physician's office and that amount is deducted from the physician's capitation fund. This is true even though the facility where the laboratory procedures are carried out belongs to the same HMO.

Now the Wisconsin Hospital Rate-Setting Commission has made some recommendations. One is that Methodist Hospital in Madison reduce its staff by 18 full-time equivalent employees and that Divine Savior Hospital in Portage reduce its staff by about 26 full-time employees.

Is there no limit to the number of regulating agencies? And just who regulates the regulators?

What next?

—*Victor S Falk, MD,* Edgerton

Skulduggery in the Senate

ORIGINALLY, THIS PIECE was to be entitled "Sanity in the Senate." The budget bill passed by the Wisconsin Assembly included a provision mandating all insurance plans to include coverage for chiropractic services. This provision was never voted on separately but was part of an omnibus 58-item amendment proposed by the Assembly Democratic leadership. Seventeen widely diverse organizations urged the State Senate to reject the language mandating such chiropractic coverage which they described as "disturbing and counter-productive to see a special interest group (chiropractors) attempting to foster cost increases by mandating additional health care benefits." Among the groups opposing the mandate were Region 10 of the United Auto Workers, the Coalition of Wisconsin Aging Groups, the Office of the State Insurance Commissioner, and the Federation of Cooperatives.

Despite the opposition of the caucus of the Senate Democrats and the President of the Senate, the chiropractic coverage, through some very adroit maneuvering, managed to remain in the state budget bill. The bill was finally passed by a weary band of legislators. Although the budget bill was a totally inappropriate place for such legislation, it provided that as a three-year test, chiropractic coverage would be required in all health insurance plans and participants would be allowed 28 visits annually. The number of visits permitted was an absurdity in itself.

Fortunately, Governor Anthony Earl had the wisdom to veto the mandated chiropractic coverage. The mandate had been vetoed in the past years by acting Governor Martin Schreiber and again by Governor Earl. The Medical Society is appreciative of Governor Earl's courage and perception in defeating this measure.

Just as inevitably as the weeds come up in the spring, the well funded and highly organized chiropractic lobby promotes one bit of legislation favorable to chiropractic. They met with success for several years, but more recently their outrageous demands for compulsory chiropractic coverage have been vetoed by governors. Whereas the chiropractors are able to devote their entire effort to a single project at each legislative session, the State Medical Society is involved in hundreds of bills relevent to medicine. The Society opposes some, favors others, and at times makes requests that certain legislative measures be introduced. For example, SMS is seeking legislation currently in eight major areas—only one of which is

professional liability which constitutes an enormous legislative agenda on its own. This broad base of pertinent legislation spreads the Society staff and concerned physicians over a thin layer. Unfortunately most physicians tend to be pretty apathetic about legislative involvement.

—*Victor S Falk, MD,* Edgerton

Editorial Board comment: *There are still those, even in the Legislature, who do not understand that as the coverage of any insurance broadens, its use increases and the costs to the purchaser go up. Then comes the screaming about escalating healthcare costs, and those who opposed the increased coverage get blamed for the increased cost. No matter what—we can't really win, but thanks to Governor Earl we have a respite.*

—"that made Milwaukee famous"

THE PRODUCT THAT made Milwaukee famous is no longer brewed there. However, two medical terms have brought fame to Milwaukee.

One is the "Milwaukee brace" designed by Dr Walter Blount. The other is "Milwaukee shoulder" first described by Dr Donald J McCarty of Milwaukee in 1981.[1]

Doctor McCarty indicated that the features of "Milwaukee shoulder" include: 1) the occurrence predominately in older women; 2) shoulder pain and marked limitation of motion; 3) large recurrent shoulder effusions characterized by mononuclear cells with a low leukocyte count; 4) concomitant glenohumeral osteoarthritis and/or rotator cuff tear; and 5) the presence of hydroxyapatite on crystal analysis of the aspirated synovial fluid.

The condition is not as rare as supposed as another rheumatologist (Weiss[2]) reported an additional four cases. Weiss pointed out that the "Milwaukee shoulder" syndrome should be considered the diagnosis in elderly women who present with shoulder swelling, pain, and limited mobility. X-ray studies should show osteoarthritis of the shoulder, and arthrography will demonstrate a rotator cuff tear or adhesive capsulitis. Synovial fluid aspiration findings include copious, viscous, often bloody fluid with a low leukocyte count. Electron microscopy of the fluid will reveal the presence of hydroxyapatite crystals. Weiss states the treatment consists of repeated shoulder aspiration followed by injection of an intra-articular steroid preparation when needed. Appropriate therapy has allowed elderly patients who were otherwise faced with nursing home placement to continue self-care and independent living.

—*Victor S Falk, MD,* Edgerton

[1]McCarty DJ, Halverson PB, Carrera GF, et al: "Milwaukee shoulder"—association of microspheroids containing hydroxyapatite crystals, active collagenase, and neutral protease with rotator cuff defects. 1. Clinical aspects. *Arthritis Rheum* 1981; 24:464.

[2]Weiss JJ, Good A, Schumacher HR: Four cases of "Milwaukee Shoulder," with a prescription of clinical presentation and long-term treatment *J Am Ger Soc* 1985; 33:202■

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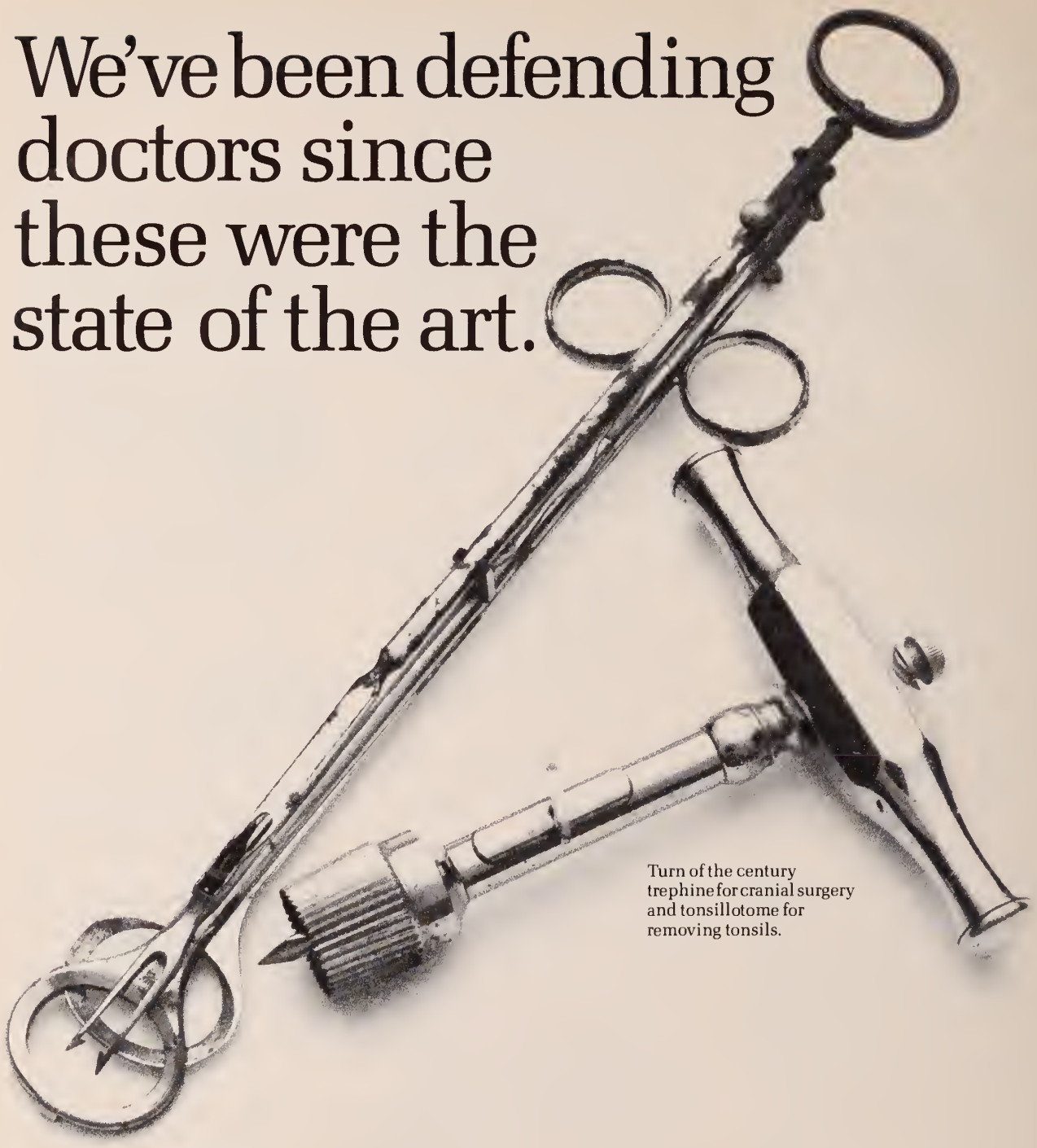

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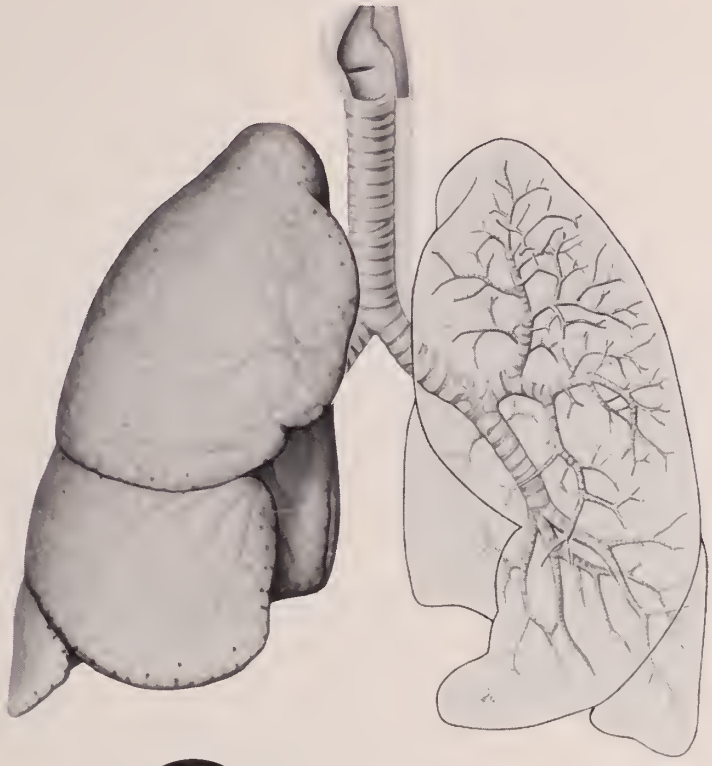

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Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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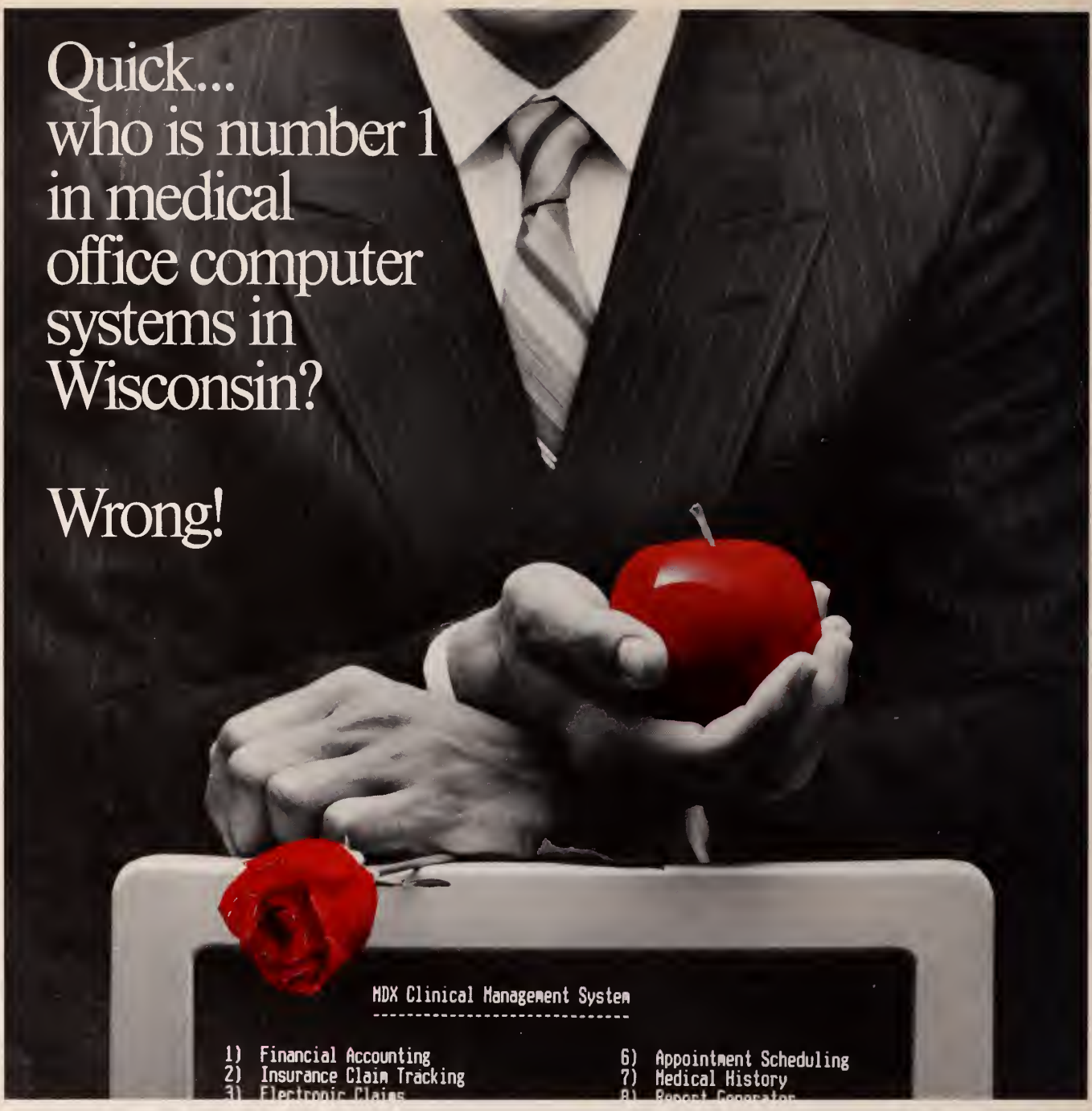

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Bone scan changes in a marathon runner; case report

Gary N Guten, MD and *Dan Craviotto, BS*
Milwaukee, Wisconsin

ABSTRACT. *A case report of a 34-year-old marathon runner with degenerative changes in his left knee is presented. Bone scans were done prior to and after a recent marathon during a symptomatic period. A 10% increase of osteoblastic activity in the symptomatic knee and a 3% increase in the asymptomatic knee were found. Patients with subjective and objective findings prior to a marathon should be advised to reevaluate their intense running goals.*

Key words: Bone scan; Running

THE REPETITIVE microstresses of long distance running and the association of long distance running with musculoskeletal injury are recognized by most clinicians and researchers.[1-6] We present a case history of a marathon runner in whom changes were studied in pre-marathon and post-marathon bone scans. Rarely is there the opportunity to study these stresses objectively by the bone scan technique.

Case history. The patient is a 34-year-old runner who has been a long distance runner and marathon runner for 16 years. He has qualified for the Boston marathon in sub-three hour marathon times, and he runs 50 to 60 miles per week on asphalt or paved surfaces. He has a history of intermittent left knee difficulty secondary to his ten-year involvement in football and wrestling. Medial and lateral partial menisectomies were done in 1981 and 1982.

He had an excellent year of marathon running in 1983 and had no difficulties until late September 1983 when he developed pain and swelling in his left knee after a 16-mile run. Physical examination in October revealed slight thickening along the lateral joint line with tenderness along the lateral aspect of the knee and distal femur. There was no effusion. There was also medial joint line tenderness and slight crepitation. X-ray studies were suggestive of early osteonecrosis of the lateral femoral condyle and early degenerative changes of the medial compartment (Fig 1). A bone scan was done (Fig 2) and the patient was advised not to participate in any marathon running because of the marked osteoblastic activity noted on the bone scan. However, against medical advice, the patient competed in a marathon approximately one week later and finished at a 3.00 pace. His knee was extremely painful and stiff, and he was seen again with a slight effusion and increased tenderness and crepitation. A second bone scan was done approximately 15 days after the original scan and ten days after the run.

Methods. Technetium 99m methylene diphosphonate was used in both scans.[7-9] Time from injection to scanning was approximately the same, the dose was exactly the same, and the areas of interest were set on the computer to reflect similar localized sites.

Results. Comparison of the pre-marathon bone scan on October 5, 1983 with the post-marathon bone scan on October 20, 1983 revealed a 10% increase in activity over the 15-day period. This excess scan activity was localized to the surface of the distal femur and the

Figure 1: *Standing x-ray film of patient's knees. On the patient's left, note early joint narrowing and degenerative changes, and cystic changes in the femoral condyle.*

Figure 2: *Bone scan prior to marathon. Note intense osteoblastic activity of the left knee.*

Doctor Guten is Director of the Sports Medicine Institute at Good Samaritan Medical Center, Milwaukee; Mr Craviotto is a senior medical student, Medical College of Wisconsin, Milwaukee. Reprint requests to: Gary N Guten, MD, 940 North 23rd St, Milwaukee, Wis 53233. Copyright 1985 by the State Medical Society of Wisconsin.

lateral tibial plateau. The normal unaffected side showed a 3% increase in activity after the marathon.

Discussion. Although there are hazards in drawing conclusions from a single case, this case shows a 10% increase in bone scan activities after a marathon in a knee with preexisting degenerative changes. The normal knee showed a 3% increase in bone scan activity and the patient experienced no symptoms in his normal knee. The lesson to this patient and other marathon runners is that they must learn to "listen to their bodies." Athletes, running coaches, and health providers should be aware that pain in the knee prior to a long distance run is a symptom that caution should be taken when doing a long distance run. Long distance running will continue to be a good form of aerobic activity with excellent maintenance of musculoskeletal and cardiovascular strength. However, some caution is necessary in a joint which is painful prior to the marathon. This study demonstrates that destructive changes and osteoblastic activities occur after the marathon in symptomatic joints. Each runner must evaluate the risk reward ratio of any long distance run. In this particular case the accelerated degenerative changes in the knee will probably override the cardiovascular benefits of intense marathon running in this patient. Alternative aerobic exercise such as swimming or biking is definitely indicated in this patient.

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ABSTRACT

Splenic phagocytic function after partial splenectomy and splenic autotransplantation

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Partial splenectomy and splenic autotransplantation have been advocated as preferable alternatives to total splenectomy in order to avoid an increased risk of infection associated with excision of the spleen. We investigated splenic reticuloendothelial activity after splenic preservation procedures to determine their effect upon the phagocytic function of the spleen. Sprague-Dawley rats had either a sham laparotomy, total splenectomy, hemisplenectomy, subtotal splenectomy, or total splenectomy with intraperitoneal splenic autotransplantation. Nine weeks later, phagocytic function of the spleen was determined by measuring organ uptake of Technetium-99m sulfur colloid. Splenic phagocytic function after hemisplenectomy, subtotal splenectomy, and total splenectomy with autotransplantation were significantly reduced when compared to sham-operated animals. In order to correct for differences in splenic weight between experimental groups, a splenic phagocytic index was calculated. Mean splenic phagocytic indices for sham laparotomy (42.2 ± 2.9), hemisplenectomy (44.9 ± 2.9), and subtotal splenectomy (43.2 ± 5.2) were similar; however, the phagocytic index was reduced markedly after autotransplantation (15.8 ± 2.2, $p<0.0001$ *vs* all other groups).

These data indicate that the phagocytic function of the spleen after hemisplenectomy and subtotal splenectomy correlates highly with the weight of the splenic remnant; however, splenic phagocytic function after splenic autotransplantation remains reduced even after accounting for differences in splenic weight.

This suggests that reticuloendothelial activity of the spleen is proportional to splenic weight after partial splenic resections but that function after autotransplantation is impaired during regeneration of the autotransplanted spleen.■

Silo-filler's disease

A historical perspective and report of a case

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ABSTRACT. *The various oxides of nitrogen are produced by the fermentation process in dairy silos. These irritative toxic gases can produce a clinical spectrum ranging from immediate asphyxiation to delayed respiratory distress and with subsequent permanent lung damage. A case is reviewed and measures to prevent this tragic occurrence are described.*

Key words: Silo-filler's disease; Toxic organic gas

THE FIRST FARM silos used in American agriculture were constructed in about 1875.[1] This method of forage preservation then came into rather general and widespread usage. The picture of farm buildings with an associated silo is now a standard portrait of a dairy farm.

This method of preserving feed for dairy cattle is similar in concept to the packing and fermentation that preserve certain foods for human use. An example is the conversion of cabbage to sauerkraut.

As with many technological advances, there developed associated environmental concerns or dangers, and this report is a review of the hazards of the silo gases generated during the fermentation process.

It is so often the case that the index description of a disease correctly describes the clinical condition and the cause. That is certainly true in the first reported description of sudden death in a silo. Hayhurst and Scott[1] described a tragedy at the Ohio State Hospital (Athens) in 1914 in which four inmates of the institution jumped into a silo that was filled to about 12 feet from the top and were then asphyxiated. These authors collected the silo gas for analysis in the Department of Chemistry at Ohio State University. The gas was composed of 38% carbon dioxide, 13.5% oxygen, and 48.5% of the oxides of nitrogen. Since the deaths in the silo were sudden and appeared due to asphyxiation, it was concluded that asphyxiation was caused by the carbon dioxide concentrations in the silo, but the authors correctly noted the high concentration of the oxides of nitrogen in the silo.

There were previous medical descriptions in the German literature of the toxic effects of nitric oxide fumes[2] and an article in 1912 by Wood[3] described the effects of industrial exposure.

Toxic irritative gases were used in World War I and reviewed in a 1920 article by Winternitz[4] and a 1955 paper by McAdams[5] of the Army Chemical Center.

By 1917, Wagner had described the pathologic finding of bronchiolitis obliterans following the inhalation of acrid fumes in general[6] and Blumgart et al described bronchiolitis obliterans occurring, not only after inhalation of the fumes of hydrochloric acid and nitric acid but also after some infectious diseases such as measles or whooping cough.[7] He gave credit to an initial description by Lang in 1901 differentiating bronchiolitis obliterans from other pathologic conditions such as indurating pneumonia, disseminated bronchopneumonia, and organizing pneumonia.[8]

In the 1930s radiologists became aware of the dangers of burning nitrocellulose films liberating carbon dioxide and nitrous oxide with the transformation on exposure to air of the nitrous oxide to nitrogen dioxide, the toxic gas. Nichols[9] noted that, in the presence of water or moisture, nitrogen dioxide liberates free nitric acid, and he indicated free nitric acid as the causative agent of the toxic effects of the oxides of nitrogen in the human lung.

In 1932 LeRossignol[10] described irritants and gases affecting workers in a silo. He felt that the danger of gases in a silo may be due to carbon dioxide with asphyxiation, respiratory irritation from volatile acids, or allergy following sensitization caused by exposure to protein-containing dusts. This article set the stage for the eventual separation of the immediate and delayed effects of silage gas exposure and even the allergic types of exposure such as farmer's lung.

In 1949 Peterson et al[11] of the Wisconsin College of Agriculture described the yellow silo gas as occurring in the reduction of nitrates to nitrites and the liberation of nitrous acid. Being very unstable at the temperature of silage, nitrous acid would break up into nitric oxide (NO) and nitrogen dioxide (NO_2). The authors noted that the production of this yellow silage gas stops within about ten days of the filling of a silo.

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During the intense industrial effort of World War II there were descriptions of nitric fumes produced by welding and arising in the welding arc. For instance, Camiel et al[12] noted that nitric fumes occur in industries where nitric acid is used such as in the production of sulfuric, picric, and chromic acids and in the manufacture of celluloid and nitrocellulose (gun powder), and in the manufacture of artificial leather, and the production of explosives such as nitroglycerin or dynamite. In 1951 Fostvelt[13] described a case of silage gas poisoning and attributed the anesthesia or unconscious state of the victim to asphyxia due to carbon dioxide and made no mention of exposure to the oxides of nitrogen. In this article were recommendations for adequately ventilating the silo area prior to and during entry. The US Department of Agriculture bulletins had been warning of gas danger in silos since May 1939.[14]

In 1956 Grayen[15] and Lowry[16] published articles describing silo-filler's disease as a "new disease in agricultural workers." These articles correctly blamed delayed respiratory effects on exposure to nitrogen dioxide in silage gas and attributed the first reported case to Delaney[17] in 1956.

By 1958 Leib et al[18] described *chronic* pulmonary insufficiency secondary to silo-filler's disease. In the same year Dickie et al[19] separated out diseases such as farmer's lung or interstitial pneumonitis due to exposure to moldy forage. In 1960 Cornelius et al[20] correctly pointed out that the degree and type of injury depends primarily upon the intensity and duration of exposure. By 1961 the condition of a severe relapse in respiratory symptoms following a latent period after exposure was described by Rafii and Godwin.[21]

In the 1960s there were more detailed clinical, physiologic, and pathologic studies[22-24] of individual patients, and a long-term followup of a case was described in 1971 by Ramirez et al.[25] Another long-term followup was published in 1973 by Scott and Hunt[26] and a case report by Fleethaus.[27] Finally, to get us to the space age, lung toxicity from exposure to nitrogen dioxide has resulted from an accident in a titan missile silo.[28]

Case report. A 54-year-old married, white, male farmer was brought to the emergency room because of extreme shortness of breath. He had finished filling his silo with corn silage about 10 am. Seven hours later he climbed into the structure to reassemble the forage unloader and to begin throwing silage down by hand. He was in the silo about one hour, and during that time, noticed that he was coughing. His wife standing near the silo chute recalled an odor like "bleach" and noticed yellow-brown gas flowing down the chute of the silo. The blower that was normally used in the silo was not present, as it was needed at a different silo. A few hours after leaving the silo the patient's cough increased and he became short of breath. By 11:30 pm when he arrived at the emergency room, he was cyanotic with a PO_2 of 37. Extreme respiratory distress prompted intubation and respiratory support. There was no previous history of silo-filler's disease or of farmer's lung and he was known to be a nonsmoker.

In October 1980 the patient had been resuscitated from myocardial infarction with ventricular fibrillation.

Physical findings included apprehension, respiratory distress, bilateral wheezing, and cyanosis. Body temperature was 37.3 C (99.2 F) rectally. Blood pressure was 158/80 mmHg. Pulse rate was 94 and regular.

The initial chest film showed fluffy bilateral alveolar infiltrates consistent with acute pulmonary edema. The electrocardiogram showed a pulse rate of 95 with left atrial enlargement, nonspecific ST-T wave changes, and Q-waves in the anteroseptal leads consistent with previous myocardial infarction. Initial blood hemoglobin was 17.2 Gm/100 ml, white blood cell count was 21,900 per cu mm, serum uric acid was 10.1 units, serum creatinine was 1.4 units, and blood urea nitrogen was 28 Gm/100 ml. Initial blood gases included PCO_2 of 77, PO_2 of 37 and pH of 7.15. Serum hemoglobin was 202 with normals being 33 to 140. Farmer's lung antigen was done and showed that antibodies were present to *Micropolyspora faeni* in a titer of 1:320 and antibodies were present to *Aspergillus fumigatus* in a titer of 1:160.

The hospital course was characterized by full respiratory support for five days and the use of nasal oxygen for another seven days. The patient was initially treated with hydrocortisone 150 mg intravenously every six hours and later prednisone 80 mg per day tapering to 40 mg per day on discharge. Intravenous fluids with aminophylline were administered during the early hospitalization.

At the time of followup examination approximately one month after discharge, the patient was still taking prednisone 40 mg every morning. Arterial blood gases on room air showed PO_2 of 60, PCO_2 of 36, pH of 7.52. Forced vital capacity was 3.18 which was 67% of predicted. Both forced vital capacity and the forced expiratory volume had improved since pulmonary function studies were done in the hospital. The chest film showed minimal interstitial densities and was near normal. Blood pressure had decreased to 114/80 mmHg. Uric acid had returned to normal levels. Blood urea nitrogen had

decreased from 28 to 22 units and the creatinine had decreased from 1.4 to 0.9. The patient had returned to work and was again able to perform normal farm duties, including reentering the silo which had then been adequately ventilated.

Discussion. The fermentation process in a silo liberates carbon dioxide and lactic acid from carbohydrates; and nitrates are formed from the nitrogen content of the forage. The nitrates then oxidize into the various oxides of nitrogen. Potassium nitrate by anaerobic fermentation is changed into potassium nitrite and oxygen. These nitrates combine with organic acids in silage to form nitrous acid (HNO_2). As the temperature of the ensilage rises with fermentation, the nitrous acid decomposes into water and a mixture of nitrogen oxides which include nitrogen trioxide (N_2O_3), nitric oxide (NO), nitrogen dioxide (NO_2), and nitrogen tetroxide (N_2O_4). The nitrogen trioxide is a brown gas, the nitrogen dioxide a red gas, and nitrogen tetroxide a yellow gas. Nitric oxide is colorless. Nitric oxide is a very stable gas. Nitrogen dioxide readily polymerizes and has an offensive odor. Nitrogen trioxide dissociates very rapidly into NO and NO_2. Nitrogen tetroxide decomposes to NO_2.

Nitrogen dioxide in the presence of moisture or water forms nitric acid, the irritant that causes lung damage and acute pulmonary edema. Nitrogen tetroxide (N_2O_4) reacts with water to produce nitric and nitrous acids.[29]

It is of interest medically as an aside that nitrous oxide or nitrogen monoxide (N_2O) was discovered by Priestly in 1772, and Sir Humphrey Davey noted that inhalation of this gas may relieve pain. In December 1844 the first clinical application of nitrous oxide as an anesthetic agent occurred in the United States. This nitrous oxide is a colorless inert gas and at high temperature may decompose into nitric oxide which may form nitric acid and cause pulmonary edema.[30]

Because silos without adequate ventilation are closed structures, the silo gases, being heavier than air, tend to collect just above the silage. During the addition of silage and prior to closing or covering the silage, farmers may jump into the silo to spread the silage in an even manner and to cover it.

The concentration of silage gases is greatest in the first ten days after forage is added to the silo. In the event that a farmer jumps into a silo with a high concentration of carbon dioxide and nitrogen dioxide, asphyxiation may be immediate. More commonly, the concentration is less intense and the farmer notices an irritating smell similar to that of bleach or ammonia and may see the yellow-reddish-brown gases. As a result, work in the silo continues and the symptoms may not occur until hours later, developing and increasing in severity like a sunburn that becomes more apparent many hours after the exposure.

In many cases the severity of cough and dyspnea seem to decrease in the next few days and then, from two to three weeks following exposure, an apparent delayed reaction occurs which may even be fatal. Untreated, this syndrome coincides with the formation of bronchiolitis obliterans.

Bronchiolitis obliterans is a pathologic lesion that results when injury to small conducting airways is repaired by proliferation of granulation tissue. It is the same final common pathway of lung injury that may be seen with fume exposures, infections, drugs, connective tissue diseases, and allergic reactions. Histologically, bronchiolitis obliterans is characterized by plugs of granulation tissue involving bronchioles and alveolar ducts together with extension of the organization from distal alveolar ducts into alveoli with variable degrees of interstitial infiltration by mononuclear cells. Fibrosis is usually uniform in age suggesting that all repair begins at the same time. The distribution is patchy with preservation of background architecture.[31]

In acute exposure the radiologic signs are those of bilateral pulmonary edema. In the delayed reaction there occurs a miliary type of involvement appearing similar to miliary tuberculosis. This, too, coincides with the pathologic changes of bronchiolitis obliterans.

Treatment depends upon the clinical presentation of the exposure. In overwhelming asphyxiation the treatment is traditional resuscitation and life support measures after removal of the individual from the gaseous environment. The delayed reaction with severe shortness of breath and pulmonary edema needs to be evaluated and monitored with arterial blood gases. In our reported case we feel that the early use of the respirator turned a potentially fatal case into a case of survival with minimal residual.

It is generally agreed that corticosteroids in high doses are beneficial and that, although they may be gradually decreased they should be continued for four to six weeks after severe exposure to prevent development of bronchiolitis obliterans and permanent respiratory damage and insufficiency.[16,21,32]

One must differentiate this disease from an allergic lung disease such as farmer's lung due to moldy silage or other moldy farm forage. It is, of course, possible for a farmer to have both farmer's lung and to suffer respiratory changes due to exposure to toxic

caustic silage gases. Clinically our patient had silo-filler's disease, but also his serum was positive for farmer's lung antibodies.

As is the case with medical illnesses, the best approach consists of educating the farm population to the dangers of silo gases, especially during the first ten days after filling the silo, and to preventive measures such as adequate ventilation of the silo with blowers prior to its entry.

Finally, should exposure occur, understanding of the pathophysiology and various clinical presentations will lead to proper and correct treatment with a minimum of respiratory damage, mortality, or morbidity.

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Neisseria meningitidis serogroup Z as a cause of meningitis

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ABSTRACT. A case of *Neisseria meningitidis* serogroup Z meningitis in a 19-year-old male is presented. The patient was successfully treated with aq. Penicillin-G. This is the first case of serogroup Z meningitis in a young adult in the United States.

Key words: *Neisseria meningitidis;* Epidemiology; Vaccines

IN RECENT YEARS there has been a shift in the serogroups of *Neisseria meningitidis* responsible for meningitis. Initially groups A, B, C were responsible for most infections, more recently there has been an increase in cases caused by the less well recognized groups such as Y, and W-135. We report here what we believe to be the first case of group Z meningitis in a young adult in the United States.

Case Report. A 19-year-old male was in good health until he developed an occipital headache of sudden onset while shoveling snow. The severe headache persisted that day, along with development of a stiff neck, backache, nausea, vomiting, fever and photophobia. The patient was brought to an emergency room of a local hospital after be became increasingly clumsy and lethargic.

In the emergency room his temperature was 38.3 C (101 F) and he was obtunded. A computerized tomographic (CT) scan of his head showed no intracranial hemorrhage. A lumbar puncture was performed with an opening pressure of 540 mm H_2O. The

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cerebrospinal fluid (CSF) was cloudy with a white blood cell count (WBC) of 6,300 per cu mm with 100% neutrophils. The CSF protein was 486 mg/dl and CSF glucose was 37 mg/dl (simultaneous blood glucose was 178). Gram stain revealed Gram-negative diplococci. Culture of CSF was positive for *Neisseria meningitidis*. The peripheral WBC count was 26,400 per cu mm with 36% band forms. The patient was transferred to Milwaukee County Medical Complex.

Upon admission, the patient was somnolent and his temperature was 38.7 C (101.6 F). He had positive Kernig's and Brudzinski's signs. There were no signs of meningococcemia. The patient was treated with aqueous penicillin G for 10 days. Blood, throat, and nasal cultures were negative. Counter immunoelectrophoresis (CIE) of CSF isolate revealed it to be *Neisseria meningitidis* group Z. The patient had an uneventful recovery.

Discussion. In a review of the literature, only one other case of serious meningococcal disease caused by serogroup Z in the USA was found. In that case a two-year-old boy had fatal fulminant meningococcemia with dissiminated intravascular coagulation (DIC) and meningitis.[1] In that same report[1] a case of group X meningococcemia and meningitis was also reported. In the United Kingdom a case of group Z meningitis was reported in a woman after rhinoplasty.[2] One could postulate that the surgery led to bacteremia with this common carrier group. In this report we have presented a case of group Z meningitis without meningococcemia or an identified predisposing cause.

Currently the most frequently encountered serogroups include B, C, and Y. Recently there has been an increase in meningococcal disease by groups Y and W-135, approaching the frequency of groups B and C.[3-7] Group Y appears to cause a milder disease with a greater occurrence of pneumonia, arthritis, and respiratory tract disease.[8] Serogroup Z is usually associated with the carrier state, most commonly isolated from the throat and sputum, and rarely from blood.[3] The cases cited above represent the only known reports where group Z has been isolated from the CSF. Even military personnel have not seen any cases of group Z disease, according to Dr W Zollinger at Walter Reed Army Hospital (personal communication). Because the rarer serogroup, namely W-135, X,Y,Z,Z^1, rarely causes systemic disease, it has been suggested that they may be less virulent or that there exists a greater immunity to them in the population.[8] But our review of the literature has shown that these groups can cause severe clinical disease and, therefore, can be just as virulent as the more common groups.

The emergence of these rarer serogroups as causes of disease may influence research on vaccines. Currently groups A and C vaccines are available, and military personnel have been using a tetravalent vaccine of A, C, Y, and W-135 for the last year. All four vaccines are safe in adults,[9] but Y and W-135 have not been tested in children and C cannot be used in children under two. Group B meningococcus is still the most common pathogen but vaccine preparation has been difficult due to nonimmunogenicity of the capsular polysaccharide. If the incidence of the rarer serogroups continues to increase, especially due to the use of group Y and W-135 vaccines in the military, the addition of group Z or perhaps all serogroups to a vaccine preparation may become necessary.

Sulfonamide resistance is also of interest relative to these newer serogroups. Group Y has been studied extensively because of its recent increase in incidence, and in the majority of Y isolates the organism was sensitive to sulfonamides.[8] Sulfa resistance in group Z is low, although it hasn't been as well-quantified because of its rare occurrence.[10] Knowledge of the specific serogroup and its sulfa sensitivity are important in prophylaxis of close contacts, especially when rifampin may be unavailable or contraindicated such as due to allergy, in children under five, in patients with active liver disease and in patients on oral contraceptives where its effectiveness is impaired.

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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral iluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

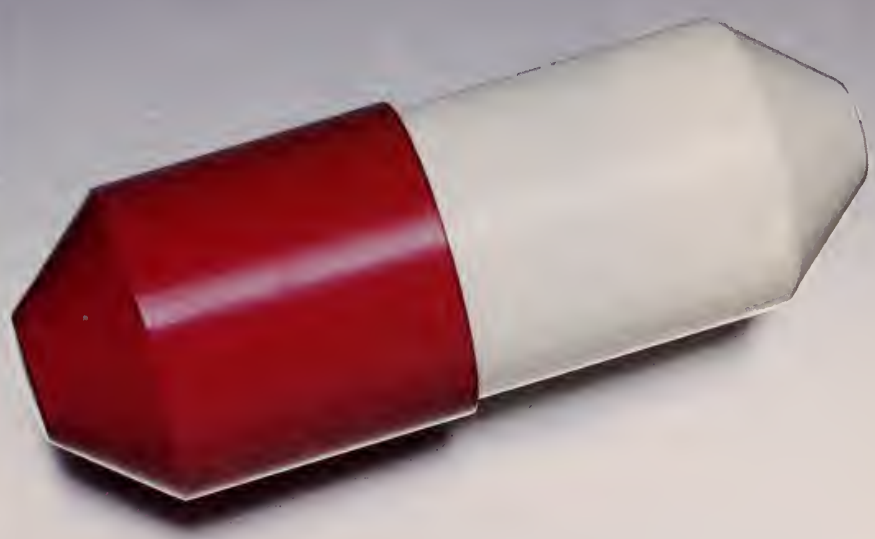
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L39

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 19 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.

a product of

SK&F CO.

Carolina, P.R. 00630

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Help her compute America's future.

Today, our children are computing basic math. Tomorrow, they'll be programming the future.

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BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

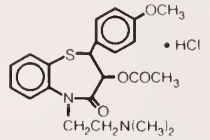
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

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SMS June 29 Board Meeting results

The SMS Board of Directors met in Madison Saturday, June 29, and took the following action:

• **Peer review**—Approved physician appointments to the newly created SMS Task Force on Physician Review and Discipline. The task force, chaired by Peter Eichman, MD, Madison, was created in response to the SMS Secretary's report at the 1985 Annual Meeting. Its charge is to "evaluate and make recommendations for the improvement of physician review and discipline in the state of Wisconsin."

• **Medical liability**—Approved physician appointees to the Task Force on Medical Liability created by the SMS Executive Committee on June 6. Chaired by William Listwan, MD, West Bend, the purpose of the task force is to monitor the current liability situation and to examine in-depth a series of research projects relative to long-term solutions to the medical liability problem.

• **Health consequences of nuclear war**—Agreed to co-sponsor a conference on "Nuclear Decision-Making:Past, Present and Future" to be held in Madison on October 25 and 26, 1985. Other sponsors include the UW Dept of Letters and Science, UW Office of International Studies, UW Dept of History, UW Dept of Medicine, UW Dept of Scandanavian Studies, Physicians for Social Responsibility and Educators for Social Responsibility.

• **Litigation**—Decided not to become party at this time to the case *Sherman, et al v Wisconsin Patients Compensation Fund, et al* which is challenging the constitutionality of the Patient Compensation Panel System.

• **Medical liability**—Supported a provision in the Legislative Council's bill on medical liability which would change the statute of limitations for physicians who are state employees from the current 120 days to the standard three years which applies to private practicing physicians. The Board also went on record as supporting another provision in the bill which would include state-employed physicians in the Patients Compensation Fund and the Patient Compensation Panel System. The Board noted that Medical College of Wisconsin faculty pay assessments and premiums which are 42% of the full rates.

• **Psychiatric conference** — Agreed to co-sponsor with the Wisconsin Psychiatric Assn and others a conference on "Sex in Therapy—Restructuring Broken Lives" to be held September 13 and 14, 1985 in Milwaukee.

• **Medicaid medical audit**—Decided to continue the SMS Medicaid Medical Audit contract with the Dept of Health and Social Services providing anticipated amendments are acceptable. Under the contract, SMS serves in an advisory capacity with DHSS with regard to the appropriateness, quality and quantity of medical services provided by physicians to Medicaid recipients.■

Medicare changes due October 1

Physicians who are currently treating Medicare patients and are interested in changing their provider status (participating or nonparticipating) are reminded that they must do so by October 1, 1985. A change in provider status can be obtained by writing Wisconsin Physicians Service, Attn: CPCU, 1717 West Broadway, Madison, WI 53716. SMS cautions participating physicians who change to nonparticipating status that they may want to examine their fees closely because as a nonparticipating physician they must remain at the same level they had at the second quarter of 1984. This may mean that some physicians may have to roll back their current charges to Medicare patients. If you have questions on this issue, contact Michelle Scoville at SMS offices toll-free at 1-800-362-9080, or 608-257-6781.■

Physicians honored

The Board of Directors has presented Distinguished Service awards to retired Board members Charles W Landis, MD and Joseph L Teresi, MD. The awards were presented at the Board's June meeting. Doctor Landis began his service to the Board of Directors in 1980, the year he was elected president-elect of the Milwaukee County Medical Society. He was elected to the SMS Board of Directors in 1984. This April the SMS House of Delegates elected Doctor Landis president-elect of the State Medical Society. *continued* ►

► *continued*

Doctor Teresi began his service to the County Medical Society's Board in 1978, the year he was elected secretary-treasurer of the Society. He retired from the Board in 1984.

The Wisconin Chapter of the American Academy of Pediatrics has named Carl S Eisenberg, MD, Pediatrician of the Year for 1985. Doctor Eisenberg is a member of the State Medical Society Board of Directors, an assistant clinical professor at the Medical College of Wisconsin, and on the staff of the Milwaukee Medical Clinic.■

Museum receives grant

The Fort Crawford Medical Museum, operated by the Society's Charitable, Educational and Scientific Foundation, has been awarded a $1,000 grant from the Institute of Museum Services of the National Foundation on the Arts and Humanities. The grant is earmarked for the Medical Museum to take part in a Museum Assessment Program operated by the American Association of Museums.■

Citizens' conference on AODA scheduled

The Second Annual Citizens' Conference on Alcohol and Other Drug Related Problems will be held Thursday, September 26 at the Mead Inn in Wisconsin Rapids.

The State Medical Society and its Charitable, Educational and Scientific Foundation are assisting in sponsoring the conference in order to share with citizens the most recent information on AODA problems as well as obtain ideas to significantly reduce AODA related problems in the state.

Workshop topics will focus on: AODA and the Criminal Justice System; Community Organization and Advocacy; Drug Abuse Treatment Trends; Legislation; Fetal Alcohol Syndrome; Intoxicated Driver Program; Innovative Prevention/Intervention Approaches and AODA and Health. For registration and other information contact Arlene Meyer at SMS offices toll-free at 1-800-362-9080 or at 608-257-6781■

Financial planning seminar set, October

SMS Services, Inc has scheduled a "Personal Financial Planning Seminar" for October 3 at the Marriott Inn in Brookfield. The program will be highlighted by presentations on the new marital property law which will go into effect January 1, 1986.■

Fund fee assessments due

Patients Compensation Fund fee assessments were mailed to physicians in early July. All physicians (not exempt by virtue of limited practice or government employment) are required to pay the Fund fee assessment.

The billing notice indicates that payment is due by July 27, 1985, but the Fund Director has advised SMS that because of delays in mailing the notices, physicians will be given 30 days from receipt of the notice to pay the assessment.

As reported in a previous *Medigram,* 1985-86 Fund fee assessments are being increased by 90% over last year's level. However, the current amount due is *equal* to the 1984 fee assessment. The 90% increase will be billed in two installments; in January and April of 1986. This billing procedure is necessitated by state statute which provides that if proposed rate changes are not approved by June 1, then the previous year's rate level is billed and adjustments made at a later date. Due to intense SMS and member opposition to the 160% increase, the final rate change was not approved by the statutory deadline.

In addition, the Fund is in the process of establishing an installment payment plan. The 1985-86 assessment must be paid according to the following schedule:

- amount equal to 1984 rate due now,
- ½ of 90% increase due in January 1986, and
- ½ of 90% increase due in April 1986.

Beginning in July 1986, physicians will have the option of paying the Fund fee assessment in full or in quarterly installments. The schedule of payment for Patients Compensation Fund fee assessments for 1985-86 is as follows:

Schedule of payment for Patients Compensation Fund fee assessments for 1985–86

Class	*Current Amount Due*	*January Payment*	*April Payment*
1	$ 952.00	$ 428.50	$ 428.50
2	1,905.00	857.50	857.50
3	2,449.00	1,102.00	1,102.00
4	2,939.00	1,322.50	1,322.50
5	4,899.00	2,204.50	2,204.50
6	5,878.00	2,645.00	2,645.00
7	6,858.00	3,086.00	3,086.00
8	476.00	214.00	214.00
9	10,287.00	4,629.00	4,629.00

■

Doctor Pomainville honored at Medical Museum

Leland C Pomainville, MD of Wisconsin Rapids was honored July 12 by the Charitable, Educational and Scientific Foundation of the State Medical Society when the Foundation dedicated a new reading room, in his honor at its Medical Museum in Prairie du Chien.

Those present at the ribbon-cutting ceremony, in addition to Doctor Pomainville, were Prairie du Chien Mayor James Bittner, CES Foundation President Robert T Cooney, MD, Portage, and State Medical Society Secretary Earl R Thayer of Madison.

Doctor Pomainville served as treasurer of the CES Foundation for 19 years until his retirement earlier this year.

A native of Waumandee, Wisconsin, Doctor Pomainville earned his medical degree from the University of Wisconsin Medical School in Madison in 1931.

Following his internship and residency at Milwaukee County General Hospital, Doctor Pomainville returned to central Wisconsin and began his practice of medicine with his uncle, Dr F X Pomainville, and his cousin, Dr Francis Pomainville, in Wisconsin Rapids. In 1939 he opened his own office.

During World War II, Doctor Pomainville served in the South Pacific as a Navy surgeon.

In addition to his practice of medicine, Doctor Pomainville is well-known as a historian. He is a charter member of the South Wood County Historical Corporation and has held various offices in that organization. He was the first regional chairman of the Wisconsin Council for State and Local History, an affiliate of the Wisconsin Historical Society, and was the recipient of a commendation from the American Association of State and Local History.

Over the years Doctor Pomainville has made countless contributions to the CES Foundation and its Medical Museum in Prairie du Chien. Besides serving as CES treasurer, for sixteen years he presented the Beaumont Award to an outstanding Doctor of Surgery at the Society's Annual Meeting. He was instrumental in the development of a special display for the Medical Museum featuring family doctors and is a member of the "Beaumont 500," a group of individuals who have given generous support to the Museum. For many years he served as the State Medical Society's historian.

In dedicating the new reading room in honor of Doctor Pomainville, CES Foundation President Robert T Cooney, MD said: "May all who use the Pomainville Reading Room gain as much insight from books, history, and through the sheer love of learning as the man for whom the facility is named."■

Doctor Pomainville in the reading room

Cutting the ribbon . . . Doctor Pomainville and Dr Robert Cooney

On page 131 of the June 1985 BLUE BOOK issue, the following correction should be made:

Leif Erickson Sr, MD, 440 South Perkins Blvd, Burlington, WI 53105 is the chairman of the Section on Family Physicians.

Also, on page 133 the president of the Wisconsin Academy of Family Physicians is ***Leif Erickson Sr, MD,*** 440 South Perkins Blvd, Burlington, WI 53105; and the Executive Director of the Wisconsin Society of Internal Medicine is Sandra M Koehler, 611 E Wells St, Milwaukee, WI 53202; Tel: 414/276-6445.

On page 123 of the June BLUE BOOK issue, the Environmental and Occupational Health Committee should read as follows:

Environmental and Occupational Health

This committee shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

Melvin S Blumenthal, MD, Monroe, 1986
Jacob Martens, MD, Wausau, 1986
Robert W Page, MD, Marshfield, 1986
Wendelin W Schaefer, MD, Sheboygan, 1986
Ruth R Schuh, MD, Watertown, 1986
Carl Zenz, MD, West Allis, 1986
John S Moore, MD, Milwaukee, 1987
Henry A Anderson III, MD, Madison, 1987
John J Beck, MD, Sturgeon Bay, 1987
Erwin S Huston, MD, Milwaukee, 1987
John T Schnitz, MD, Milwaukee 1987
Raymond Johnson, MD, Milwaukee, 1987
Lawrence Smith, MD, Racine, 1987
Paul F Durkee, MD, Janesville, 1988
James T Paloncek, MD, Milwaukee, 1988
Vernon N Dodson, MD, Madison, 1988, Chairman
Larry A Lindesmith, MD, La Crosse, 1988, V-Chairman
Edward P Horvath Jr, MD, Marshfield, 1988
Charles W Fishburn, MD, New Berlin, 1988
Susan M Wester, MD, La Crosse, 1988
Mrs W W (Jane) Schaefer, Sheboygan, Auxiliary■

AMA Physician's Recognition Award recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

APRIL 1985

Barry, Daniel J, Madison
*Bixby, Mark R, Grantsburg
*Blau, Edward B, Marshfield
*Breadon, George E, Monroe
*Burko, Henry, Milwaukee
Chia, James Kuao-Young, Wood
*Cohen, David A, Edgerton
Cusick, Joseph F, Milwaukee
Duffy, Thomas M, Kenosha
*Gardner, James D, Waukesha
*Gingrass, Ruedi P, Milwaukee
*Grundahl, Alvin T, West Bend
*Holtey, Warren J, Marshfield
*Koob, Lynn D, Rice Lake
*Kreul, Randolph W, Racine
*Kulkoski, Bernard, Denmark
*Larson, Sanford J, Milwaukee
*Meyer, Glen A, Milwaukee
*Mulligan, Gerald M, Marshfield
*Nowinski, Donald M, Wausau
*Patton, Charles H, Racine
*Plautz, Arthur C, Janesville
*Riegel, Fred B, St Croix Falls
*Saarinen, David M, Ashland
*Sackett, Joseph F, Madison
*Sajjad, Syed M, Marshfield
*Schmidt, Mary H, Marshall
*Schroeder, Norman J, Beaver Dan
*Sellers, Robert L, Superior
*Shahbandar, Hassan, Appleton
*Tipping, Stuart J, Marshfield
Walker, William E, Milwaukee
Walsh, Patrick R, Milwaukee
*Washington, William L, Marshfield
*Williamson, Warren H, Racine
*Winters, Thomas F, Waukesha

MAY 1985

*Abellera, R Mario, La Crosse
*Aufderheide, John F, Oshkosh
*Bacon, Glenn A, Racine
Bennett, Lawrence N, Madison
*Bernardoni, Robert J, Darlington
*Bock, Harvey M, Milwaukee
*Boren, Clark H, Marinette
*Brauer, Warren A, Sheboygan
*Browell, John N, Marshfield
*Buchanan, Keith E, Appleton
*Burgarino, Joseph J, Milwaukee
Chuang, Tsu-Yi, Madison
*Danforth, R Clarke, Milwaukee
*Evert, Howard A, Menomonee Falls
*Feinsilver, Donald L, Milwaukee
*Ferrer, Modesto M, Tomahawk
*Frase, Louis H, Eau Claire
*Gehring, John V, Green Bay
Goodman, David A, Madison
*Gueldner, Terry L, Manitowoc
*Herdrich, Gary M, West Bend
*Jacobson, Foster J, Milwaukee
*Keller, Thomas A, Manitowoc
*Kropp, August D, Milwaukee
Linkus, Kevin A, Madison
*Mc Kenna, John E, Antigo
Nordin, John R, Milwaukee
*Onderak, Edward P, Beloit
Perez, Celestino M, Port Washington
*Rakow, Robert W, Milwaukee
Schmitz, Stephen R, Hudson
*Schwartz, Herschel M, South Milwaukee
*Speichinger, James P, Madison
*Stineman, William F, Milwaukee
Stula, Gojko D, Milwaukee
Thomason, Jessica L, Milwaukee
*Trevino, Rudolfo N, Milwaukee
*Wagner, Marvin, Milwaukee
*Webster, Stephen B, La Crosse
*Yerex, Joyce A, Racine
*Young, William W, St Croix Falls■

*Members of the State Medical Society of Wisconsin

Statewide network set up for AIDS testing

The State Division of Health has compiled a list of physicians who would be interested in working with HTLV-III positive clients. A statewide network has been established by the State Division of Health to deter individuals from donating blood in order to learn their HTLV-III antibody status.

Pre-test and post-test counseling will be provided at the testing sites; however, the State Division of Health anticipates that ongoing medical, dental and psychological care will be needed by those who test antibody positive. Therefore, to address this need the Division of Health has compiled a list of providers interested in working with these clients. Any questions about the statewide testing program should be directed to Ms Holly Dowling at (608) 267-3583.

Following is a list of alternate testing sites for HTLV-III:

Southeastern Wisconsin

Brady East STD Clinic, 1240 East Brady St, Milwaukee; 414/273-2437

Herpes Health Center, Saint Anthony's Hospital, 1004 N 10th St, Milwaukee; 414/271-1965, ext 754

Marquette University Student Health Services, Schroeder Complex, Milwaukee; 414/224-7184

Milwaukee Health Department, 841 North Broadway, Milwaukee; 414/278-3621

Sixteenth Street Community Clinic, 1036 South 16th St, Milwaukee; 414/672-1353

UW-Milwaukee Student Health Services, University of Wisconsin-Milwaukee, Norris Health Center, Box 413, Milwaukee; 414/963-4716

West Allis Health Department, STD Clinic, 7120 West National, West Allis; 414/476-3770

Waukesha County Health Department, 515 West Moreland Blvd, Waukesha; 414/548-7646

City of Kenosha Health Department, 625 52nd St, Kenosha; 414/656-8170

Racine Health Department, 730 Washington Ave, Racine; 414/636-9498

Sheboygan City Health Department, City Hall Annex, 709 North 7th St, Sheboygan; 414/459-3485

South Central and Southwestern Wisconsin

Beloit Stateline Clinic, 539 Blackhawk Blvd, South Beloit; 815/389-3583

Beloit Student Health Services, Beloit College, Beloit; 608/365-3391, Ext. 331

Blue Bus Clinic, 1552 University Ave, Madison; 608/262-7330

Madison Department of Public Health, City-County Building, 210 Monona Ave, Room 507, Madison; 608/246-4516

Northeast Family Medical Center, 3209 Dryden Dr, Madison; 608/241-9020

Wingra Family Practice Clinic, 777 South Mills St, Madison; 608/263-3111

Verona Family Practice Clinic, 524 West Verona Ave, Verona; 608/845-9531

Grant County Public Health Nursing Service, Courthouse, Lancaster; 608/723-6416

UW-Platteville Student Health Services, 725 West Main St, Platteville; 608/342-1891

Northeastern Wisconsin

Fond du Lac City Health Department, 160 South Macy St, Fond du Lac; 414/929-3290

UW-Oshkosh Student Health Services, 777 Algoma Blvd, Oshkosh; 414/424-2424

Winnebago County Public Health Department, 725 Butler Ave, Winnebago; 414/235-5100, 414/725-2653

North Central Wisconsin

Oneida County Nursing Services, Courthouse, Rhinelander; 715/369-6111

Portage County Health Department, 817 Whiting Ave, Stevens Point; 715/345-5350

UW-Stevens Point Student Health Services, Delvin Hall, Stevens Point; 715/346-4646

Northwestern Wisconsin

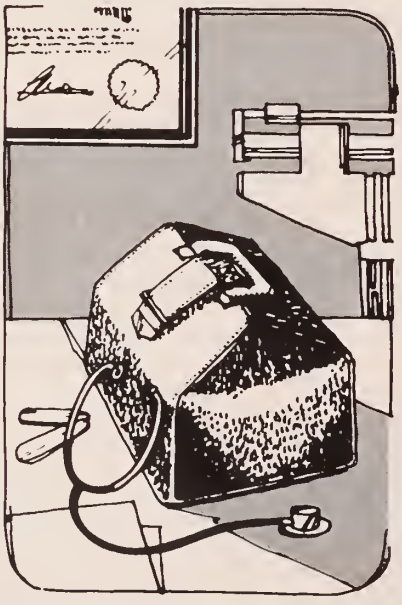
UW-La Crosse Student Health Services, 1725 State St, La Crosse; 608/785-8559

La Crosse Health Department, STD Clinic, Grandview Building, 1707 Main St, La Crosse; 608/785-9723

UW-River Falls Student Health Services, 409 Spruce St, River Falls; 715/425-3292■

To all my patients,

Partners in Good Health



The State Medical Society of Wisconsin announces a new program designed to improve physician-patient communications and encourage greater patient feedback.

The program, entitled "Partners in Good Health," contains statement stuffers, reception area brochures, patient feedback questionaires and a certificate of participation to be displayed in the reception area.

Program brochures are available in quantity by writing to:

The Communications Department
State Medical Society of Wisconsin
P.O. Box 1109
Madison, WI 53701

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EXCHANGE OF INFORMATION

QUESTIONS AND CONCERNS

INFORMED CONSENT

IN THE HOSPITAL

FEES FOR SERVICES

HEALTHY LIFESTYLE

Prepared and distributed
by the State Medical Society of Wisconsin

James Bloom, MD, Prairie du Chien, has joined the medical staff of Prairie Medicine, Ltd. Doctor Bloom graduated from the University of Iowa School of Medicine and completed his family practice residency program in Mason City, Iowa. A diplomate of the American Academy of Family Physicians, Doctor Bloom was in private practice for four years in Charles City, Iowa, prior to moving to Prairie du Chien.

Eric Nimmo, MD, Platteville, recently became associated with the Southwest Health Center and is practicing in Cuba City and Shullsburg. Doctor Nimmo graduated from the Medical College of Wisconsin, Milwaukee, and completed his family practice residency with St Michael Family Practice Program which is affiliated with the Medical College of Wisconsin.

Ramakrishna Vennam, MD, Seymour, has joined the medical staff of the Hittner Clinic in Seymour. Doctor Vennam graduated from Gunter Medical College in India and completed his residency in Boston and in Kansas City.

Frank J Pulito, MD,* has joined the medical practice of Karen K Cowan, MD* in Kiel. Doctor Pulito graduated from Marquette University Medical School and completed his internship at Milwaukee County General Hospital. He served in the United States Navy during the Korean War. Doctor Pulito had been in general practice in the Milwaukee area and was a staff physician at Southern Wisconsin Center for the developmentally disabled. He served as president of the Milwaukee Neuropsychiatric Society in 1977-1978.

Richard D Sautter, MD,* director of medical education at the Marshfield Clinic, has been appointed an assistant dean for clinical affairs at the University of Wisconsin Medical School, Madison. Doctor Sautter graduated from the University of Nebraska Medical School and completed his internship at Highland Alameda County Hospital, Oakland, Calif. His residency was served at the University of Iowa. Prior to joining the Marshfield Clinic, Doctor Sautter was an instructor at the University of Iowa Medical School.

Edwin L Overholt, MD,* director of medical education at the Gundersen Clinic, La Crosse, has been appointed an assistant dean for clinical affairs at the University of Wisconsin Medical School in Madison. He graduated from the University of Iowa Medical School, and completed his residency training at Fitzsimons General Hospital, Denver, Colo. Prior to joining the Gundersen Clinic, he was chief of the Department of Medicine at Fitzsimons General Hospital.

Patricia McGuire, MD, Chippewa Falls, has joined the medical staff of St Joseph's Hospital. Doctor McGuire graduated from St Louis University School of Medicine and completed her residency at Gundersen Medical Foundation, La Crosse, and also at Mayo Clinic in Rochester.

Robert H Ehrhart, MD recently opened his medical practice in Sheboygan. Doctor Ehrhart graduated from the University of Pittsburgh School of Medicine and served an internship at Bellevue Hospital in New York. His residency was completed at Walter Reed Army Medical Center, Washington, DC. He most recently completed a tour of duty as a major in the US Army Medical Corps.

Ean H Crennell, MD, Oshkosh, has joined the medical practice of Stephen S Dudley, MD, Ltd. Doctor Crennell, a graduate of Trinity College, University of Dublin, served a residency at the University of Wisconsin Medical School, Madison. He also had trained at the Mayo Clinic, and was an anesthesiologist in Madison for 18 years before entering the specialty of ophthalmology.

John F Andrews, MD, Green Bay, recently joined the medical staff of the Beaumont Clinic. Doctor Andrews graduated from the University of Minnesota Medical School and completed his residency at the University of Chicago Hospital and Clinics and at Michael Reese Hospital and Medical Center. He previously had practiced in Virginia, Minn.

James F Baumgartner, MD,* West Bend physician for 39 years, is retiring from medical practice. Doctor Baumgartner had been associated with the General Clinic of West Bend. He graduated from Marquette University School of Medicine and served his internship at the US Naval Hospital in San Diego. He has served as president of the Washington County Medical Society, was chief-of-staff of St Joseph's Community Hospital, and is a charter member of the board of directors of St Joseph's Community Hospital.

Susan M Piechowski, MD, Green Bay, has joined the medical staff of the Beaumont Clinic in the Department of Internal Medicine. Doctor Piechowski graduated from the University of Wis-

consin Medical School and completed her residency at the William Beaumont Hospital, Royal Oaks, Mich. She previously had practiced in Virginia, Minn.

Thomas J Knutson, MD, Peshtigo, recently opened his medical practice in Peshtigo. A 1980 graduate from the University of Wisconsin Medical School, Madison, Doctor Knutson completed his family practice residency in Cheyenne, Wyo. He also has been doing emergency medicine work at Menominee County Lloyd Hospital.

Francis P Larme, MD,* New Holstein, has received the "1985 Distinquished Service Award" from the University of Wisconsin Medical Alumni Association. Doctor Larme has practiced family medicine in New Holstein since 1946 and has been a member of the Calumet Memorial Hospital medical staff since 1956 serving in all officer and committee chairman positions. Doctor Larme was active in the development and construction of Calumet Homestead, the 104-bed skilled nursing care home for which he has served as medical director since its opening in 1957.

David C Thies, MD,* Waukesha, recently has become associated with the Doctors Clinic of Elkhorn. He graduated from the University of Iowa Medical School and completed a residency program at Waukesha Memorial Hospital and the Medical College of Wisconsin. He also has been involved as a part-time emergency room physician at Oconomowoc Memorial Hospital, at the Waukesha County VD Clinic and with Planned Parenthood of Wisconsin, Inc.

Richard E Rieselbach, MD,* Bayside, associate dean for the Milwaukee Clinical Campus of the University of Wisconsin's Medical School, has been chosen to receive a Robert Wood Johnson Health Policy Fellowship for 1985-86. Doctor Rieselbach is professor and chairman of Mount Sinai Medical Center's Department of Medicine. He is a 1958 graduate of Harvard Medical School and has been associated with the University of Wisconsin since he became an instructor in medicine in 1965.

George H Lind, MD* and **Pamela B Wolfe, MD,*** husband and wife team from Shell Lake, have opened the Clinton office of the Beloit Clinic. Doctors Lind and Wolfe graduated from the University of Wisconsin Medical School, Madison, and completed their residency at Mt Sinai Medi-

cal Institute in Milwaukee. They had practiced in Shell Lake for the past three years.

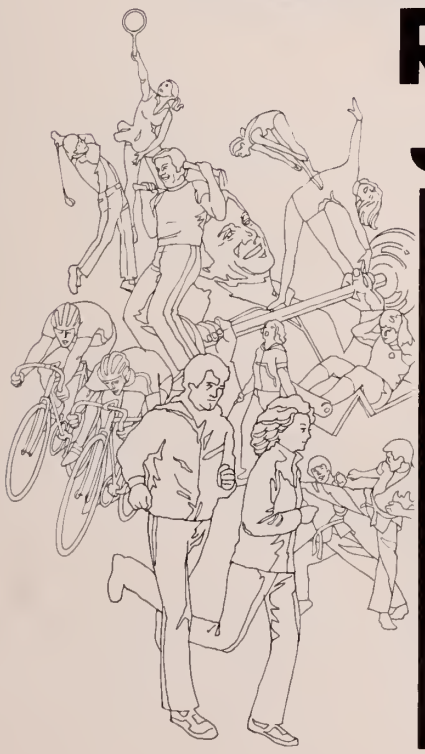
Scott Peschke, MD, Plymouth, has become associated with the Plymouth Clinic. Doctor Peschke graduated from the University of Wisconsin Medical School, Madison, and completed his residency training in Wausau.

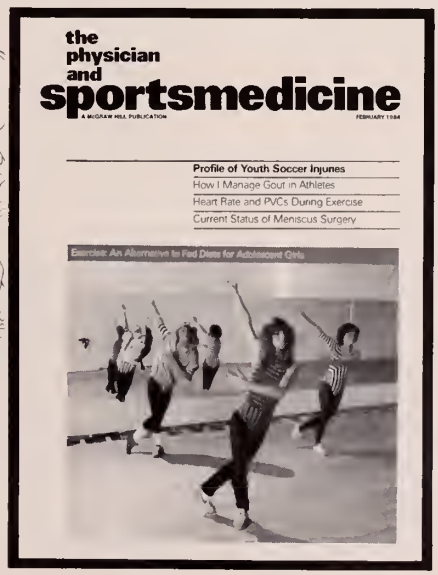
Harold F Hardman, MD,* PhD, Brookfield, recently received the Medical College of Wisconsin's "Distinguished Service Award." Doctor Hardman had served as the chairman of the school's department of pharmacology and toxicology. He is a past president of the Federation of American Societies for Experimental Biology, and also has served as president of the National Association for Medical School Pharmacology Chairmen from 1978 to 1980.

Jack A Klieger, MD,* Elm Grove, has received the Medical College of Wisconsin's "Distinquished Service Award." Doctor Klieger was recognized for his 40 years of teaching and practice of obstetrics and gynecology at the Medical College. He was instrumental in establishing the high risk obstetrics program at St Joseph's Hospital where he was director of perinatology from 1976-1984. He also served as chairman of the Department of Obstetrics and Gynecology from 1958-1970. He is a graduate from the Marquette University School of Medicine.

Marvin Wagner, MD,* Fox Point, was named "Alumnus of the Year" by the Medical College of Wisconsin. He is clinical professor of surgery and professor of anatomy at the Medical College and has served on the faculty for 35 years. In 1980 he received the Physician's Recognition Award of the American Medical Association and the Distinguished Service Award of MCW. He graduated from Marquette University Medical School in 1944.

OVER 66,000 FAMILY PHYSICIANS READ THIS JOURNAL





Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.

Timothy Wolter, MD, Chippewa Falls, recently became associated with MDs Paul M Ipel* and Robert S Lea* in Chippewa Falls. Doctor Wolter graduated from the University of Minnesota School of Medicine and has completed his family practice residency in Sioux Falls, S Dak.

Vernard A Benn, MD,* Rosholt, recently retired from his medical practice of 49 years. Doctor Benn graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at the Medical College of Virginia in Richmond. He has no exact count of the number of babies he delivered, but knows it's "something over 5,000."

Martin E Klabacha, MD, Woodruff, recently became associated with the Lakeland Medical Associates of Woodruff, Park Falls, and Phillips. Doctor Klabacha graduated from Loyola University Stritch School of Medicine and completed his residencies at Indiana University, Loyola University, and the Oregon Health Sciences University. He most recently has been practicing in the Chicago area.

Albino L Settimi, MD,* Elm Grove, has assumed the newly-created position of Vice President for Medical Affairs at Good Samaritan Medical Center. Doctor Settimi has had offices in Elm Grove for more than 20 years and has been on the medical staff at Deaconess Hospital and the Masonic Diagnostic Center. ■

CES Foundation

of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of May 1985.

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Community Conference issues medical ethics statement

MILWAUKEE: The Community Conference on Medical Ethics was formed in 1984 by the Medical Society of Milwaukee County's immediate past president, John P Mullooly, MD.* The mission was to advise the Medical Society's Board of Directors of medical/ethical issues in the community and draft statements on ethical issues for consideration by the Board. The statement on ***The Withdrawal of Nutrition and Hydration in Terminal Adult Patients*** is the first completed work of the Conference. The advisory statement was approved for publication in the Society's Membership Newsletter as an official statement of the Medical Society of Milwaukee County. The Conference is comprised of physicians from the Society's regular Ethics Committee and eight community and religious leaders. Conference members who drafted the statement are: Christopher J Drayna, MD;* Richard P Barthel, MD;* Harry R Foerster Jr, MD;* Patrick Coffey, Marquette University Department of Philosophy; Rev Richard Eyer, Columbia Hospital; Sandra Christensen, Executive Director, Kindcare; Sister Gabrielle Kowalski, Cardinal Stritch College; Charlotte Theis, Marquette University School of Nursing; Rev Willard Steiner; Rev Dick Robinson, Elmbrook Church; and Connie Pukaite, Executive Director, Association for Retarded Citizens.

The Withdrawal of Nutrition and Hydration in Terminal Adult Patients

Statement of the Community Conference on Medical Ethics. Approved by the Board of Directors of the Medical Society of Milwaukee County, May 1985

IN ALL SOCIETIES, provision of food and water is perceived as a critical part of human nurturing and caring for one another as well as a physical necessity of life. Decisions regarding the provision of nutrition and hydration should be made in this context.

It shall be our position that it is obligatory to provide nutrition and hydration except in certain circumstances.

Exceptions may be justified in the following health care contexts:

1) The patient is comatose and has an imminently terminal condition wherein provision of nutrition/hydration will only lengthen the dying process.
2) The patient is irreversibly comatose, has no terminal illness, and the physician has reasonable knowledge that the *patient previously expressed* desire for such withdrawal in such circumstances.
3) The patient is terminally ill, comatose, and/or incompetent, and hydration/nutrition is causing or would cause considerable physical suffering.
4) The patient is terminally ill, competent, informed, understands the consequences, and chooses to refuse nutrition/hydration.

FOOTNOTE: Although the Committee respected the autonomy of the patient in drafting these guidelines, there were also concerns for those who are asked to assist the patient in his/her possible choice of refusal of nutrition/hydration (i.e. physician nurse, institution, etc.), and for what a refusal of nutrition/hydration does to a society's morale, value for life, and sense of community. An individual's autonomy may be a sign of isolation, loneliness and despair, which needs to be addressed.

DEFINITIONS. ***Terminal Illness:*** For the purpose of these guidelines, it is agreed that terminal illness is an irreversible condition which will cause the patient's death in the foreseeable future. A time frame which is bounded by weeks to months and less than one year.

Imminently Terminal: For the purpose of these guidelines, it is agreed that the term imminently terminal is a time frame bounded by hours to days.■

OUTAGAMIE: Fifteen members were present at the May meeting of the Outagamie County Medical Society. Guest speakers were Ron Henrichs, Director of Communications and Membership, and Deborah Bowen Wilkie, Field Representative, both of the State Medical Society. Mr Henrichs spoke on "The REACH Program" and Mrs Wilkie spoke on the "Change in Malpractice Premiums." New officers for 1985-86 took place and they are MDs: Marvin L Hall,* president; Nancy J Homburg,* vice president, and David R Finch,* secretary-treasurer, all of Appleton.

WINNEBAGO: Thirty-nine members and guests were present at the May meeting of the Winnebago County Medical Society held in Oshkosh. Ms Terry Hottenroth, lobbyist for the State Medical Society spoke on the "1985 Legislative Goals."■

Wisconsin Academy of Family Physicians, at its 37th Annual Meeting June 12-15, elected James L Esswein, MD,* Cameron, as its president-elect for 1986-87. Doctor Esswein will succeed Lief W Erickson, Sr, MD,* Burlington, who is serving as president for 1985-86. Theodore C Fox, MD,* Antigo, received the 1985 "Family Physician of the Year" Award at the meeting. He is a past president of WAFP. John L Raschbacher, MD,* Waukesha, was honored as the 1985 "Family Practice Educator of the Year," and just recently retired as director of the Family Practice Residency Program at Waukesha Memorial Hospital. He was nominated for this award by many of his former students. Curt G Grauer, MD,* Wausau, received the 1985 "Geriatrician of the Year" award for his devotion and concern for his geriatric patients.

John L Raschbacher, MD

James L Esswein, MD

Curt G Grauer, MD

Lief W Erickson, MD

Theodore C Fox, MD

Officers elected at the annual meeting were: MDs John T Bollinger,* Fall Creek, secretary-treasurer; David E Westgard,* La Crosse, speaker; Curtis W Bush,* Beaver Dam, vice-speaker; Robert F Purtell Jr,* Milwaukee, delegate to the AAFP, and John O Grade,* Elm Grove, alternate delegate. New directors elected were MDs James H Zellmer,* Milwaukee; Ann Berlage, Madison; and Alan D Strobusch,* New London. Laurence J Velinden, MD, Milwaukee, was elected as the resident representative on the Board of Directors and Mrs Barbara A Hummel,* Milwaukee, was elected as the student representative. Francis M Schammel, MD,* Stoughton, was elected chairman of the Board of Directors.

American Society of Surgery of the Hand, has elected to membership, Ruedi P Gingrass, MD,* Milwaukee. Doctor Gingrass becomes the second active member in Milwaukee and the third in Wisconsin.

Society of Thoracic Radiology, at its second annual meeting, has installed Lawrence Goodman, MD, Fox Point, president for the year 1985-86. Doctor Goodman is professor of radiology and director of pulmonary radiology at the Medical College of Wisconsin.

American Academy of Dermatology has named William C Miller, MD,* Wausau, to the Council on Governmental Liaison. Doctor Miller also is a member of the State Medical Society's Health Care Cost Liaison Committee.

American College of Utilization Review Physicians (ACURP) has accepted Muhammad Y Ahmad, MD,* Merrill, as a fellow. A main goal of ACURP, established in 1973, is to reduce cost and maintain the high quality of healthcare.

American College of Physicians recently announced the following Wisconsin physicians to fellows of the College. They are MDs Richard A Reinhart,* Marshfield, and Kristine M Lohr of Wood.

Wisconsin Chapter, American College of Surgeons, has elected the following physicians to office for the year 1985. They are MDs Wayne J Boulanger,* Milwaukee, president; Sanford Mackman,* Madison, president-elect; Roger L von Heimburg,* Green Bay, vice-president; and Paul S Fox, Waukesha, secretary who was elected to a three-year term.

"WATS" LINE FOR MEMBERS

The in-WATS (toll-free) line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

Rodney P Gwinn, MD, Sturgeon Bay, died March 10, 1985 in Sturgeon Bay. Born July 7, 1918 in Seattle, Wash, Doctor Gwinn graduated from the University of Wisconsin Medical School, Madison, and completed his residency in the Kine County Hospital, Seattle, Wash. Doctor Gwinn served in the United States Air Force during World War II and the Korean Conflict. He had been associated for 15 years at Abbott Laboratories in North Chicago, Ill, in clinical research and also was employed in the same capacity 12 years at G D Searle in Skokie, Ill. He was an associate professor in clinical medicine at Northwestern University Medical School in Chicago. He retired in Sturgeon Bay in 1982. Doctor Gwinn was a member of the Door-Kewaunee County Medical Society and the State Medical Society of Wisconsin. Surviving are his widow; two daughters, and a son.

Michael F Ries, MD, 78, Brownsville, died Mar 29, 1985 in Brownsville. Born Feb 3, 1907 in Lomira, Doctor Ries graduated from the University of Wisconsin Medical School, Madison, and served his internship at St Louis City Hospital, St Louis, Mo. Doctor Ries practiced in the Brownsville area until his retirement in 1983. He served as chief-of-staff at Waupun Memorial Hospital and also was a member of the St Agnes Hospital medical staff. He was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Margaret; three sons, Stanley, Brownsville; Thomas, Berlin; and Michael, Eau Claire; two daughters, Mrs Katherine Harden, Livermore, Calif; Mrs Paul Gotberg, San Diego, Calif; and three stepdaughters, Mrs. Velma Reichle, Philadelphia, Pa; Mrs Carol Cooke, Dayton, Ohio, and Mrs Joann Sommers, Random Lake; and two stepsons, Bruce Frei, Venice, Fla, and Warren Frei of Bettendorf, Iowa.

Rudolph P Gingrass, DDS, MD, 84, Oconomowoc Lake Village, died Apr 5, 1985 in Oconomowoc. Born Jan 20, 1901 in Baraga, Mich, Doctor Gingrass graduated from the Marquette University School of Medicine, Milwaukee, and served his internship at Milwaukee County General Hospital. He was a former member of the medical staff of St Joseph's and St Francis hospitals, and also was a consultant in Oral and Maxillofacial Surgery at the Medical College of Wisconsin and the Veterans Administration Hospital in Wood. Doctor Gingrass was a professor emeritus of Oral and Maxillofacial Surgery and also of Plastic and Reconstructive Surgery at the Medical College of Wisconsin. Surviving are his widow, Mary; and five children.

Desmond H Callaghan, MD, 78, Hayward, died Apr 9, 1985 in Duluth, Minn. Born Nov 30, 1906 in Glenwood, Minn, Doctor Callaghan graduated from the University of Minnesota School of Medicine and served his internship at St Mary's Hospital in Duluth, Minn. He served as a United States Naval Doctor with the 1st Marine Division in the South Pacific during World War II. Doctor Callaghan practiced medicine in Hayward until his retirement in 1973. He was a member of the Wisconsin Academy of Family Physicians, Barron-Washburn-Burnett County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Martha; one son, John Lansing of St Paul, Minn; two daughters, Mary Wanninger, Edina, Minn, and Jane Pederson of Rochester, Minn.

Donald D Frawley, MD, 84, former Milwaukee physician, died Mar 9, 1985 in Sun City, Ariz. Born Aug 4, 1901 in Appleton, Doctor Frawley graduated from Marquette University School of Medicine in 1925 and served his internship at New York Polyclinic Hospital. His residency was completed at the New York Eye and Ear Infirmary. He had been an attending staff member at Milwaukee Children's Hospital and a consulting physician at Misericordia Hospital and St Anthony's Hospital, Milwaukee. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. There are no immediate survivors.

Rodney B Fruth, MD, 58, Elm Grove, died Apr 13, 1985 in San Diego, Calif. Born Oct 4, 1926 in Connersville, Ind, Doctor Fruth graduated from Albany Medical College, Albany, New York. His internship was served at Indianapolis General Hospital, Ind, and his residency was completed at the Veterans Administration Hospital, Wood, Wis. Doctor Fruth was medical director of Philstan Psychiatric Clinic, Milwaukee, and also had a private practice in Elm Grove. He was a member of the Wisconsin Psychiatric Association, the American Psychiatric Association, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving is his widow, Elaine.

William E Bargholtz, MD, 80, Ashland, died Apr 27, 1985 in Ashland. Born Mar 16, 1905 in Clinton, Iowa, Doctor Bargholtz graduated from the University of Iowa Medical School and served his internship at Madison General Hospital. After internship, Doctor Bargholtz practiced medicine in Reeseville until he moved to Ashland in 1943. In the early 1950s, Doctor Bargholtz served on the State Medical Society of Wisconsin's Committee on Cancer. He also served as president of the Ashland-Bayfield-Iron County Medical Society, was a member of the "50 Year Club" of the State Medical Society of Wisconsin, and was a member of the American Medical Association. Surviving are his widow, Luella; two daughters, Susan and Betsey; and one son, William.

Bruno J Peters, MD, 73, Wauwatosa, died Apr 29, 1985 in Brookfield. Born Sept 3, 1911 in Milwaukee, Doctor Peters graduated from Marquette University School of Medicine and completed his internship and residency at Milwaukee County General Hospital. Doctor Peters served in the U S Army Medical Corps from 1942-1946. After service he returned to Milwaukee and organized the medical clinic at Allen-Bradley. He was cofounder of the Clinic of Internal Medicine in Wauwatosa, and was a long-time board member of the Marquette Medical School and the Medical College of Wisconsin. He also was a former chief-of-staff at St Luke's Hospital in Milwaukee. In 1969 he was president of the Milwaukee Academy of Medicine and also was a former president of the Milwaukee Chapter of the American Diabetic Association. In 1975 Doctor Bruno was named Alumnus of the Year of the Marquette Medical College of Wisconsin Medical Alumni Association. He retired in 1977. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his daughter, Frances Auger, Elm Grove; four sons, Stephen R, Woodruff; Michael B, Newark, Del; Thomas J, Cottonwood, Ariz, and Mark A of Portland, Ore.

Maurice H McCaffrey, MD, 84, Dunedin, Fla, died May 15, 1985 in Dunedin. Born Jan 19, 1901 in Madison, Doctor McCaffrey graduated from the University of Pennsylvania School of Medicine and had practiced medicine in Pittsburgh until his retirement. Surviving are his widow, Roberta Lee of Dunedin, and one son, Maurice of Hudson, Ohio.

Paul E Rutledge, MD, 84, Washington Island, died June 9, 1985 in Washington Island. Born Feb 4, 1901 in Danby, Mo, Doctor Rutledge graduated from St Louis University Medical School in 1927 and served his internship at St Mary's Hospital, St Louis, Mo. Doctor Rutledge practiced medicine in Missouri from 1927-1960 and then moved to Washington Island in 1961 and practiced there until his retirement in 1977. Surviving are his widow, Jean; two daughters, Mrs Gilbert (Ann) Truax, Escanaba, Mich; Mrs Clay (Jean) Blair, Washington Island; and two sons, Paul, Akron, Ohio, and Charles of Findlay, Ohio.

John Kimberly Curtis, MD, 85, Madison, died July 5, 1985 in Madison. Born Mar 14, 1905 in Redland, Calif, Doctor Curtis graduated from Columbia Medical School, and served his internship at Presbyterian and Bellevue hospitals in New York. After service in World War II, Doctor Curtis moved to Madison and entered private practice until 1951 when the Middleton Memorial Veterans Administration Hospital was opened. He was named its first Chief of Medicine. He retired in 1971. Surviving are his widow, Margaret; two sons, Kimberly, Missoula, Mont; James of Coeur d'Alene, Idaho; and one daughter, Catherine Sawyer of Santa Fe, N Mex.■

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Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1985 are $455 for SMS, $330 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin
DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Your membership in organized medicine will help insure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1985 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1985 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455	$330	Normal County Dues
Resident	45.50	45	Varies
Military Service	-0-	220 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	227.50	330*	Normal County Dues
Over Age 70	227.50	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	20	Varies
Sophomore and Succeeding Medical Student Years	10	20	Varies
Postgraduate—One	10	45	Varies

*Physicians in the following categories may be eligible for exemption from paying AMA dues: (1) Financial hardship and/or disability, (2) Age 65-69 and retired from the practice of medicine, (3) Over age 70 *regardless* of retirement status.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions*.) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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PHYSICIANS EXCHANGE

continued

West Bend, Wisconsin, General Clinic, a (18) physician multispecialty group, is seeking physicians in the specialties of Internal Medicine, Family Practice, OB/GYN, and Pediatrics. First-year salary guaranteed. Corporate membership possible after one year. Excellent fringe benefits. Located in scenic, recreational area with close proximity to Milwaukee. Please contact Hans W Schmelzling, Administrator, General Clinic, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 6tfn/85

Versatile Surgeon wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E Johnson, Ely Medical Center, Ltd, 224 East Chapman Street, Ely, Mn 55731; ph 218/365-3151. 6tfn/85

Obstetrician/Gynecologist, Board eligible/certified, for Green Bay metropolitan area. Large multispecialty clinic with excellent salary and benefits. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611 p6-9/85

MESA is on the MOVE
in
Northern Illinois, Wisconsin
and the Chicagoland Area

We are seeking Board Certified/eligible and Emergency Trained Physicians to join our growing organization.

- Compensation/Benefit Packages are highly competitive with administrative and educational support services.
- Management and Staff positions for Emergency Departments and Ambulatory Care Centers.
- Excellent communication skills and the desire to excel in Emergency Medicine is a necessity.

MESA *Medical Emergency Service Associates, SC* over 20 years of excellence in Emergency Medicine.

Contact: Ms Debbie Carsky, Director of Recruitment, 312/459-7304 (collect) or write to 15 South McHenry Road, Buffalo Grove, IL 60090. 8/85

Attractive opportunity for a Board certified/eligible family physician to establish a new community practice. The family practitioner will be eligible for full-hospital privileges at Beloit Memorial Hospital, a medium-sized acute care facility. This opportunity offers a guaranteed financial and start-up package. Inquiries or CV should be directed to Gregory K Britton, Administrative Director, Beloit Memorial Hospital, 1969 West Hart Road, Beloit, Wisconsin 53511; ph 608/364-5104. p6-8;g9/85

Excellent opportunity for a Board certified or eligible internist to practice in conjunction with an 8-member Internal Medicine Department of a 26-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 6tfn/85

Family Practice. Third Family Practice physician needed to join multispecialty group of 17 in Hartford, WI. Two branch locations. All facilities modern and well equipped. Guaranteed first year negotiable salary; usual fringe benefits. Contact: Murlin Bernd, Clinic Manager, 1004 E Sumner St, Hartford, WI 53027; ph 414/673-5745 p7-8/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone 608/263-4095 7/85-6/86

OB/GYN, and internist to join seven-doctor family practice clinic in Cloquet, Minnesota, a community of 14,000 (30,000) service area, located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped, 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally our community is noted for its excellent school system. First-year salary guarantee; paid malpractice, health, and disability insurance; vacation and study time. Contact John Turonie, Administrator, Raiter Clinic Ltd, 417 Skyline Blvd, Cloquet, Minnesota 55720. Telephone 218/879-1271. 7-9/85

Full-time physician wanted for established Urgent Care center affiliated with regional hospital. Board eligibility or certification in primary specialty required. Competitive salary. 45-hours per week. Benefit package. Paid malpractice. Incentives, medium-sized city. Family-oriented progressive community. Quality school system, cultural advantages, University, abundant outside recreational opportunities. Send CV to Dept 558 in care of the Journal. p6-8/85

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

Otolaryngologist. BC/BE to join busy ENT Department within 23-member multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611. 6-9/85

Physicians

- Board certified/eligible in family practice.
- Clinic practice in Milwaukee area.
- Family and occupational medicine.
- Attractive salary and benefits.

Send CV to: Dept 562 in care of the Journal.

Milwaukee Industrial Clinic
500 N 19th Street
Milwaukee, Wisconsin 53233
Attn: Carole Wheeler 8-9/85

PHYSICIANS EXCHANGE

continued

Internist to join satellite of multispecialty clinic in Madison, Wisconsin. Satellite is located ten miles from Madison and has one internist already practicing. Support from all departments anticipated from multispecialty clinic. Fringe benefits and salary attractive plus excellent working conditions, environment and associates. New satellite is growing and additional physician is needed to give our patients quality care. Send resume to Dept 556 in care of the Journal. p6-8/85

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 4-9/85

Internist. BC/BE to join Internal Medicine Department of multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St. Green Bay, WI 53403; ph 414/494-5611 p6-9/85

Wisconsin-BC/BE Pediatrician to assume an established position of a pediatrician leaving. Join a three-man pediatric department. Call or write: David L Lawrence, MD, 92 E Division St, Fond du Lac, WI 54935; ph 414/921-0560. p3-8/85

MEDICAL FACILITIES

Beaver Dam, Wisconsin. New medical office 1250 or 2500 sq ft office space available. Excellent opportunity for Dermatology or Allergy practice. Call 414/887-8887 or write PO Box 678, Beaver Dam, WI 53916. 5-8/85

For Sale: Coulter Cell Counter Hemo-W 2 parameter (WBC-Hgb). Two and one-half years old. Has been cared for under service maintenance agreement. Asking $1900—sells new for $5000. Call Family Practice Associates of Green Bay, Ltd, 414/433-3798. p8/85

MISCELLANEOUS

Physicians Signature Loans to $50,000. Up to 7 years to repay. Competitive fixed rate, with no points, fees, or charges of any kind. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241-6905. 10eom/83

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

SEPTEMBER 6-8, 1985: Wisconsin Society of Anesthesiologists, American Club, Kohler. g5-8/85

SEPTEMBER 12-14, 1985: Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting—30th Anniversary, the Pioneer Inn, Oshkosh. Info: Wisconsin Society of Internal Medicine, 611 E Wells St, Milwaukee, Wis 53202; ph 414/276-6445. Contact: Sandra M Koehler, Executive Director. 5-8/85

SEPTEMBER 13-14, 1985: Wisconsin Neurosurgical Society, Sheraton, Racine. g5-8/85

Wisconsin Specialty Society Meetings

- Wisconsin Society of Anesthesiologists, Sept 6-8, 1985, American Club, Kohler
- Wisconsin Society of Physical Medicine & Rehabilitation, Sept 11, 1985, Sheraton Inn, Milwaukee
- Wisconsin Society of Internal Medicine/American College of Physicians Annual Meeting, Sept 12-14, 1985, Pioneer Inn, Oshkosh
- Wisconsin Surgical Society, Sept 13-14, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Neurological Society, Sept 27-28, 1985, Paper Valley Hotel & Conference Center, Appleton
- Wisconsin Society of Otolaryngology—Head and Neck Surgery, Sept 20-22, 1985, Apple Valley Motel, Appleton
- Wisconsin Dermatological Society, Oct 26, 1985, Froederdt Memorial Lutheran Hospital, Milwaukee
- Wisconsin Orthopaedic Society, Nov 1, 1985, The Olympia Resort, Oconomowoc

SEPTEMBER 13-14, 1985: Wisconsin Surgical Society, Paper Valley Hotel & Conference Center, Appleton. g2-8/85

SEPTEMBER 20-22, 1985: Wisconsin Society of Otolaryngology—Head and Neck Surgery, Paper Valley Motel, Appleton. g6-9/85

SEPTEMBER 27-28, 1985: Wisconsin Neurological Society, Paper Valley Hotel & Conference Center, Appleton. g5-8/85

OCTOBER 4-5, 1985: *Wisconsin Association Parenteral Enteral Nutrition Third Annual Symposium: The State-of-the-Art in Nutritional Support* 1985. Marriott Hotel, Brookfield, WI. Outstanding guest speaker panel. Joni Newborn 414-289-8306 or Patricia Brosier 608-364-5011. p8/85

OCTOBER 10-11, 1985: Fall Symposium of Wisconsin Chapter: American College of Emergency physicians & Emergency Department Nurses Association. The Abbey, Fontana. g7-9/85

OCTOBER 10-11, 1985: *Update in Allergy and Clinical Immunology II.* The Inn-Tower Hotel, Madison. Sponsored by Department of Continuing Medical Education and Department of Medicine, School of Medicine, University of Wisconsin-Madison. AMA Category I, University of

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

Wisconsin CEUs. Family Practice credit has been applied for. Approximately 11 hours. Info: Ann Bailey, Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2854. 7-9/85

OCTOBER 17-18, 1985: *Frontiers of Nutrition and Cancer,* Holiday Inn, Southeast, Madison. Sponsored by University of Wisconsin-Madison, Department of Continuing Medical Education, Wisconsin Council, Department of Nutritional Sciences, University of Wisconsin-Madison; Clinical Nutrition Center; Medical College of Wisconsin, Milwaukee; American Cancer Society, Wisconsin Division; and Wisconsin Dietetic Association. AMA Category 1, University of Wisconsin CEUs, AAFP Prescribed, AOA Category 2D, and ADA—all 11 hours. Contact: Sarah Aslakson, Continuing Medical Education, Room 465B WARF, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 8/85

OCTOBER 26, 1985: Wisconsin Dermatological Society, Froederdt Memorial Lutheran Hospital, Milwaukee. g6-9/85

OCTOBER 31-NOVEMBER 1, 1985: *Critical Care Conference.* Inn on the Park Hotel, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine and Continuing Medical Education; and University of Wisconsin Hospital Trauma and Life Support Center. AMA Category I and University of Wisconsin CEUs—both approximately 12 hours. Contact: Sarah Aslakson, Continuing Medical Education, 610 Walnut St, Room 465B, Madison, WI 53705; ph 608/263-2856. 8/85

JANUARY 25—FEBRUARY 1, 1986: *Sports Medicine Cruise Seminar,* SS Constitution, Hawaiian Islands. Sponsored by University of Wisconsin School of Medicine, Continuing Medical Education. AMA Category I credit 16 hours, Family Practice credit pending, and 16 hours University of Wisconsin CEUs. Contact: Ann Bailey, Department of Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison WI 53705; ph 608/263-2854. 7-9/85

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1986-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the La Crosse Convention Center.

1986—April 17-19
1987—March 26-28
1988—April 28-30
1989—April 13-15
1990—April 26-28
1991—April 18-20
1992—April 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

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SECOND ANNUAL CITIZENS' CONFERENCE ON ALCOHOL AND DRUG RELATED PROBLEMS: BRIDGING RELATIONSHIPS
September 26, 1985 / Mead Inn Wisconsin Rapids
Keynote Speaker: John K MacIver, Attorney, Milwaukee
Workshop topics:

- AODA and the Criminal Justice System
- Community Organization and Advocacy
- Drug Abuse Treatment Trends
- Legislation
- Fetal Alcohol Syndrome
- Intoxicated Driver Program
- Innovative Prevention/Intervention Approaches
- AODA and Health

Info: Arlene Meyer, State Medical Society; 1-800/362-9080 or 608/257-6781. g7-8/85

OTHERS

SEPTEMBER 9-20, 1985 (Minnesota): *Third Annual Graduate Occupational Health and Safety Institute,* Earle Brown Continuing Education Center, St Paul, MN. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-8/85

SEPTEMBER 17-18, 1985: *Hospital Privileges and Specialty Medicine,* a joint conference of the American Board of Medical Specialties and the American Hospital Association, at the Marriott Hotel O'Hare, Chicago, Illinois. g8/85

SEPTEMBER 19-21, 1985 (Minnesota): *Pulmonary and TB Update,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-8/85

OCTOBER 17-18, 1985 (Minnesota): *Toxic Chemicals in the Workplace: Health, Legal, and Regulatory Issues,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

OCTOBER 25, 1985 (Minnesota): *Promoting Healthy Lifestyles For Pregnant Women,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

OCTOBER 31-NOVEMBER 1, 1985 (Minnesota): *Latest Trends in Patient Management: Radiology and Urology,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101. g6-10/85

OCTOBER 30-NOVEMBER 2, 1985: La Crosse Health and Sports Science Symposium. Info: Philip K Wilson, Executive Director, La Crosse Exercise Program, 221 Mitchell Hall/UWL, La Crosse, WI 54601; ph 608/785-8686. g6-9/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

NOVEMBER 1, 1985: Wisconsin Orthopaedic Society, The Olympia Resort, Oconomowoc. g6-10/85

NOVEMBER 14-16, 1985 (Minnesota): *Clinical Strategies In Primary Care Medicine,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-10/85

DECEMBER 5-7, 1985 (Minnesota): *Coronary Heart Disease: A Comprehensive Review of Principles and Practice,* Sheraton Midway Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-11/85

DECEMBER 7-11, 1985 (Florida): *12th Annual Symposium "Ear, Nose and Throat Diseases in Children: A 1985 Update,"* Palm Beach. Info: Sandra K Arjona, Dept of Pediatric Otolaryngology, Children's Hospital of Pittsburgh, 125 DeSoto St, Pittsburgh, PA 15213; ph 412/647-5466. 6, 8/85

AMA

DECEMBER 8–11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

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Dyazide®
S & L Signal Company 44
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Upjohn Company, The 39
Motrin®
United States Air Force ..... 43■

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Physician's Handbook, 21st edition. Edited by Marcus A Krupp; Lawrence M Tierney, Jr, Ernest Jawetz, PhD, Robert L Roe; Carlos A Camargo, MD. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1985. Pages: 800. Price $16.50.

Current Emergency Diagnosis & Treatment. Edited by John Mills, MD, Mary T Ho, MD, Patricia R Salber, MD and Donald D Trunkey, MD. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1985. Pages: 864. Price: $28.

Review of Medical Physiology. Edited by William F Ganong, MD. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1985. Pages: 654. Price: $22.50.■

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SENATE RURAL HEALTH CAUCUS FORMED. Senators Quentin Burdick (D-ND) and Mark Andrews (R-ND) in June announced the formation of the Rural Health Caucus, a bipartisan group of senators joining forces to provide a united voice on rural health care issues in Congress. "The problems of insuring quality health care to rural areas are growing ever more acute. A disproportionate number of America's elderly and poor citizens live in rural areas, served by fewer and fewer doctors. These doctors often must contend with outdated facilities, small staffs, and inadequate support facilities," Senator Burdick said. "Our caucus is being formed to make sure that rural America's special needs are heard as Congress establishes health care policy.

Senators Andrews and Burdick said that senators who represent rural states have joined the caucus, which will serve as a forum for exchanging information on the unique problem of rural health care. "The health problems of rural America are among the nation's most severe, yet the unique characteristics and special needs of the 59 million people living in rural areas are often overlooked," Senator Andrews said.

The senators said that the special health care problems experienced by rural residents include: 1) high infant mortality rates; 2) a high percentage of people suffering from debilitating chronic illnesses; 3) greater distances to travel to reach medical facilities; 4) greater numbers of poor and elderly patients unable to afford insurance and/or medical services; 5) low numbers of doctors, nurses, pharmacists, and other health care providers per capita; 6) aging or inadequate hospitals, clinics, and nursing homes.

"As medical costs soar, Congress must find ways to contain health care and insurance costs," Senator Burdick said. "The Rural Health Caucus will be the first line of defense against policies that don't meet the needs of the people they are meant to serve. We intend to see that the needs of rural America are not overlooked."

"Clearly, rural America faces a myriad of health problems, many quite different from those in urban areas," Senator Andrews said. "Just as the Federal Government has an obligation to deal with the problems of urban America, so does it have an obligation to help us in rural America. That obligation is not diminished just because our rural voices are fewer and spread over greater distances."

—*Health Lawyers News Report,* July 1985■

HMO UPDATE. A recent 1984 survey by Lou Harris Associates found that one-half of all physicians now have a favorable attitude towards HMOs, and the HMO patients have greater satisfaction with the quality of their physicians than non-HMO members. These findings contrast with the results of similar studies which were performed in 1980 and 1981, that determined that only 36 percent of physicians were favorably disposed towards HMOs and that HMO patients were not as satisfied as fee-for-service patients with their care.

The survey also found that HMO membership is steadily increasing. The number of privately insured US households with at least one member in an HMO rose from 6 percent in 1980 to 9 percent in 1984. Growing numbers of physicians are also considering joining an HMO. In 1981, 27 percent of physicians who knew of but did not practice in a prepayment plan in their area were thinking of affiliating with an HMO. By 1984, 46 percent of these physicians said they might join an HMO.

Employers and physicians now believe that HMOs can help control costs, according to the study. Fifty-nine percent of senior executives (compared with 48 percent in 1980) reported favorable attitudes about HMOs among senior management in the companies. Eighty-two percent of executives in companies offering HMOs report a positive experience with HMOs, and 30 percent of these executives report that HMOs have led to declining health care costs for the company.

Over two-thirds of the physicians surveyed said that HMOs are effective in controlling costs. HMOs were in many instances responsible in forcing fee-for-service practitioners to reduce their fees in order to remain competitive. The study found out that 12 percent of physicians (compared to 2 percent in 1981) had reduced their fees and 14 percent said they had reduced hospitalization among their patients in order to compete with an HMO in their area.

—*Health Lawyers News Report,* July 1985■

EXCERPTS FROM A SYMPOSIUM
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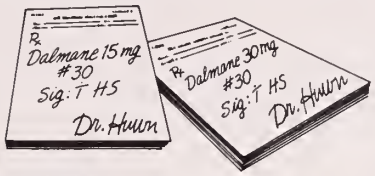
References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979 **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983 **8.** Tennant FS, *et al*: Sympasium an the Treatment af Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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WISCONSIN MEDICAL JOURNAL

Official Publication of the State Medical Society of Wisconsin

When the penalty tax comes due

President Scott offers some interesting corollaries relating to medicine when he discusses Jeremy Rifkin's book on entropy, a supreme law of nature that governs everything we do. *(See page 5)*

The urge to reverse

Doctor Rengel responds to President Scott's message on "The urge to merge" by agreeing with him that "there is great danger in this (HMO) movement," and acknowledges that physicians have "some responsibility to try to reverse this process even though it seems to be 'feuding with windmills' at this point." *(See page 12)*

Hospitals, surgeons, and free-standing surgical centers

Editorial Director Boulanger warns that free-standing surgical centers "could well prove a haven for surgeons with questionable qualifications, and their patients could be at risk." He says it would be only fair that if "free-standing surgical centers are going to be allowed to function as hospitals and skim off the profitable cases, the least they should be required to do is provide services of the same level of quality and safety as a hospital." He offers some possible solutions. *(See page 9)*

V. 84, no. 9

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CONTENTS

September 1985

SPECIAL FEATURES

President's Page

5 When the penalty tax comes due
John K Scott, MD
Madison

Editorials

9 Hospitals, surgeons, and free-standing surgical centers
Wayne J Boulanger, MD
Milwaukee

Letters

12 The urge to reverse
Thomas N Rengel, MD
Wausau

Governor's chiropractic veto action commended
John K Scott, MD, President
Earl R Thayer, Secretary
State Medical Society of Wisconsin

Miscellaneous

34 Blue Book Update

46 AMA Physician's Recognition Award Recipients

Socioeconomics

39 Medicare participating physician issue update

Brown CMS plan wins acclaim

40 WISPAC: AMPAC leader reports
William L Treacy, MD
Chairman, WISPAC Board of Directors

News you can use

54 Malpractice conference tapes available

JCAH publishes the Hospice Project Report

SMS testifies on pituitary gland removal legislation

Medicare participating physician issue update

WISPAC needs your support

SCIENTIFIC MEDICINE

15 Acute dissecting aneurysm of the ascending thoracic aorta causing obstruction and embolism of right pulmonary artery
Byung (Robert) H Kim, MD
Howard H Short, MD
Racine

18 Visceral larva migrans; a case from the La Crosse area
Frank Furlano, MD
William A Agger, MD
La Crosse

21 Anorectal giant condyloma acuminatum
R Lee Kolts, MD
Bruce C Hubert, MD
Constance S Avecilla, MD
Marshfield

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84 No. 9

CONTENTS

24 ABSTRACT: Microscopically controlled surgical treatment for squamous cell carcinoma of the lower lip
Frederic E Mohs, MD
Stephen N Snow, MD
Madison

ORGANIZATIONAL

27 SMS Board encourages negotiation in ER services

SMS Services, Inc Board highlights

28 SMS Services, Inc endorses WC program

SMS Leadership Conference October 26 in Appleton

SMS to study health data collection

Discount prices on typewriters and copiers

30 "Your doctor's new suit could cost *you* a barrel"

Financial Planning Seminar set

SMS helps sponsor sexual abuse workshop

32 Nominations sought for SMS offices

CES Foundation Annual Board meeting held

33 OBITUARIES
Harold Wagner, MD, Kenosha
Raymond G Yost, MD, Manitowoc
Lawrence G Patterson, MD, Sun Lakes, Arizona (Waupaca)
Adolph M Hutter Sr, MD, Madison (Fond du Lac)
Richard B Smith, MD, Brookfield
Marion K Ledbetter, MD, Tulsa, Oklahoma (Madison)
Earl A Hatleberg, MD, Chippewa Falls

34 CES FOUNDATION: Contributions during months of June and July 1985

41 1985 Physicians Alliance Districts and Field Consultants

48 Membership facts

DEPARTMENTS

43 PHYSICIAN BRIEFS

49 MEDICAL YELLOW PAGES
Physicians exchange
Medical Meetings/CME
Advertisers■

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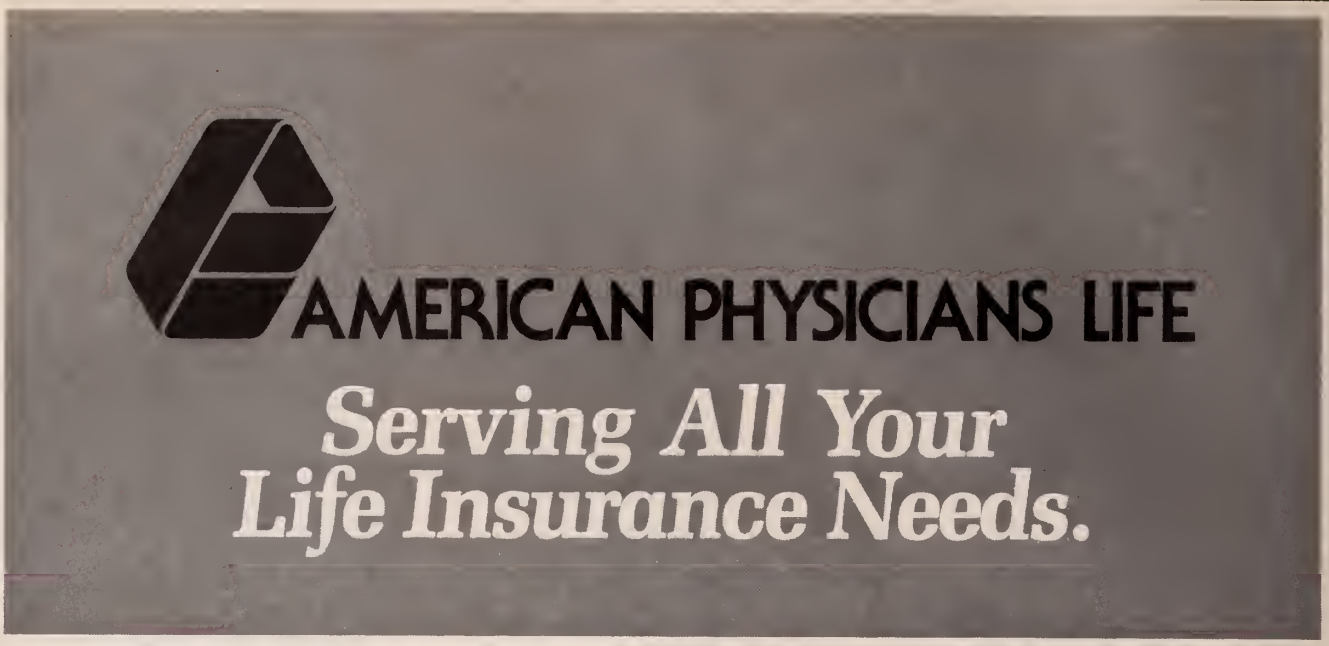

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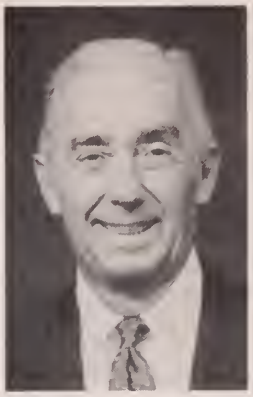

John K Scott, MD

MANY OF US WHEN in college and medical school ran across the word entropy. Entropy is a supreme law of nature and governs everything we do. I found a book recently, *"Entropy: A New World View,"* by Jeremy Rifkin. He offers some interesting corollaries relating to medicine.

The entropy law is the second law of thermodynamics. The first law states that all matter and energy in the universe is constant, that it cannot be created or destroyed. Only its form can change but never its essence. The second law, the ENTROPY LAW, states that matter and energy can only be changed in one direction, that is, from usable to unusable, or from available to unavailable, or from ordered to disordered.

In essence the second law says that everything in the entire universe began with structure and value and is irrevocably moving in the direction of random chaos and waste. According to the entropy law, whenever semblance of order is created anywhere on earth or in the universe, it is done at the expense of causing an even greater disorder in the surrounding environment. Entropy, therefore, gives us some insight into why our traditional world view is crumbling.

Applying the law of entropy to medicine, one realizes that centralization, increased specialization, and more elaborate equipment all translate into a greater expenditure of energy. As more energy has been expended in the medical field, the corresponding disorders have escalated. Although we as doctors don't much talk about it, the sad truth is that the medical profession is no more immune from the entropy law than any other activity in society.

Rifkin talks of pollution and the environment. He contends that as the dissipated waste created by our high flow-through nonrenewable energy sources continues to build up all along society's energy flow line, causing a dramatic escalation in physical disorders of all kinds, a point will be reached where the population will have no choice but to shift back into a low flow-through renewable energy base or face disease and death in epidemic proportions. His view merits our consideration.

In his book Rifkin offers many thought provoking concepts on entropy and its impact on our lives and society, but he sometimes oversimplifies the role of entropy in healthcare. He says, for example, that "most of us are now aware that what little value (entropy decrease) we receive from having x-rays done is often more than outweighed by the long-range harm of radiation exposure (entropy increase)." He goes on with another illustration of his point by stating that medically prescribed drugs produce adverse effects that "now rank among the top 10 causes of hospitalization" and account for "as many as 50 million hospital patient days a year."

While I perceive such overdramatizations to be a disservice to the profession and the public, Rifkin's writing should not divert us from serious analysis of the entropic process in relation to healthcare.

I fully agree with Rifkin's perception that our successive stages of economic and social change have greatly increased the physiological and emotional strains on the human being. We surely see this vividly demonstrated in the current and rampant changes in medical economics and their relationship to quality care for the American people. We must force ourselves to look seriously at the consequent impact of those changes on our personal outlook as the patient's advocate, on our individual and collective consciences as physicians, and on our personal physical and emotional stability in a profession under pressure.

Skeptics might grant that the entropy process is at work, but so slowly that the ultimate crisis is remote beyond human comprehension. I suggest that we in healthcare cannot be so casual. We are ever conscious of the well known "tradeoffs" in the use of drugs, x-ray, and other surgical or medical intervention as we seek to cure or relieve. We must appreciate that, in the environmental and health areas where we have special interest, the "penalty tax of entropy increase is beginning to come due."■

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Hospitals, surgeons, and free-standing surgical centers

LAST AUGUST, representatives of the Wisconsin Hospital Association and the Wisconsin Chapter of the American College of Surgeons met to discuss questions which have arisen with regard to free-standing surgical centers around the state. They found that they were in complete agreement on at least one key issue.

They agreed that current Wisconsin standards in the regulation of hospitals versus those applied to surgical centers would appear to put hospitals at a disadvantage in competing for patients.

Because of the type of patients utilizing free-standing surgical centers, the centers tend to be cheaper to operate than hospitals. Surgical center patients are usually healthy young adults who come and go within one work shift. They require no 24-hour-nursing coverage, no meal service, and minimal laboratory back-up.

That probably won't change, and in itself brings about unfair competition, but that's not the main issue. The chief concern has to do with quality of care and the protection of the patient.

For instance, Wisconsin Administrative Code H24 and federal Medicare regulations require hospitals to perform peer review through the auspices of their medical staffs. Free-standing facilities are unregulated in this regard. Nor do surgical centers have continuing medical education requirements for their medical and nursing staffs.

The whole matter of obtaining credentials and receiving hospital privileges has been spelled out pretty clearly for physicians who work in hospitals. That is not true of free-standing surgical center staffs who are selected at the discretion of the management.

In short, the surgical center could well prove a haven for surgeons with questionable qualifications and their patients could be at risk.

It seems only fair that if free-standing surgical centers are going to be allowed to function as hospitals and skim off the profitable cases, the least they should be required to do is provide services of the same level of quality and safety as a hospital. Their patients deserve no less.

A possible solution to the problem would seem to be:

1. Institution of peer review including tissue committees at free-standing surgical centers.
2. Requiring a formal affiliation with a hospital for continuing care of postoperative complications.
3. Requiring free-standing surgical centers to maintain medical records departments.
4. Setting standards similar to those of hospital staffs for granting practice privileges, and insisting that privileges be granted only to physicians who have at least one active hospital staff appointment.

Perhaps tighter regulation would tend to slow the proliferation of free-standing surgical centers. That might do much to cut the cost of medical care in the long run, even though it might lessen "competition."

—*Wayne J Boulanger, MD,* Milwaukee■

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LETTERS

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

The urge to reverse

TO PRESIDENT SCOTT: In response to your topical message "The urge to merge," (*Wisconsin Medical Journal,* July 1985, page 4) I am curious as to why in the face of what you know of human nature and foresee for the medical community, you agreed, nevertheless, to join an HMO.

I agree with Dr Arnold Relman that there is a great danger in this movement.

We physicians continue to believe that we are immune to the pressures of big business or any other force when it comes to our management of patients. This is nonsense. We are human beings like anyone else and the majority of us will succumb to the pressures no matter how high-minded our initial intentions might be or how eloquently we can advocate that this not happen.

Essentially, we are "lemmings rushing to the sea" and it is most disturbing to hear someone in your position, who obviously sees the problem well and knows so much better, proceed in this direction anyway.

The patient's best hope for a committed relationship with his personal physician has been severely compromised by this trend. We are selling the bridge, backing ourselves into a corner, and our knowledge of history should tell us that there is simply no way that the majority of us are going to be able to continue to practice the kind of medicine that our consciences tell us is best. We have families, need for job security, and peer pressure; and the large structure of an HMO simply is not going to accommodate the personal conscience of the individual physician. He will be out of a job if he bucks the system eventually. He will be at the mercy of the administration of your HMO ultimately.

I'm happy to see that you are aware of and concerned about this urge to merge. Those of us who feel as you do, I believe, have some responsibility to try to reverse this process even though it seems to be "feuding with windmills" at this point.

—*Thomas N Rengel, MD*
425 Pine Ridge Blvd, #205
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Expanded WATS telephone service

SMS members should find it easier to reach the State Medical Society at its toll-free number: 1-800-362-9080. Due to a growing volume of calls on the existing WATS line and the increasing frequency of busy signals members are experiencing when trying to use the line, SMS has installed a second incoming WATS line. The number remains the same.

Governor's chiropractic veto action commended

TO GOVERNOR ANTHONY EARL: On behalf of the State Medical Society of Wisconsin, we would like to express our sincere appreciation for your veto of the chiropractic insurance mandate in the 1985-87 biennial budget. It seems unnecessary to reiterate all of the problems associated with this type of mandate, since you are clearly well aware of the negative aspects of mandating chiropractic insurance coverage. You are to be congratulated not only for your commitment to good public policy, as evidenced by your veto of this item and your accompanying veto message but also for your courage to wield the veto pen in the face of intense political pressure to leave this item intact.

We have been in contact with a number of legislators urging them to vote to sustain this veto and are quite confident that the veto will be sustained. Again, our thanks to you for your commitment on this issue.

—*John K Scott, MD*
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—*Earl R Thayer*
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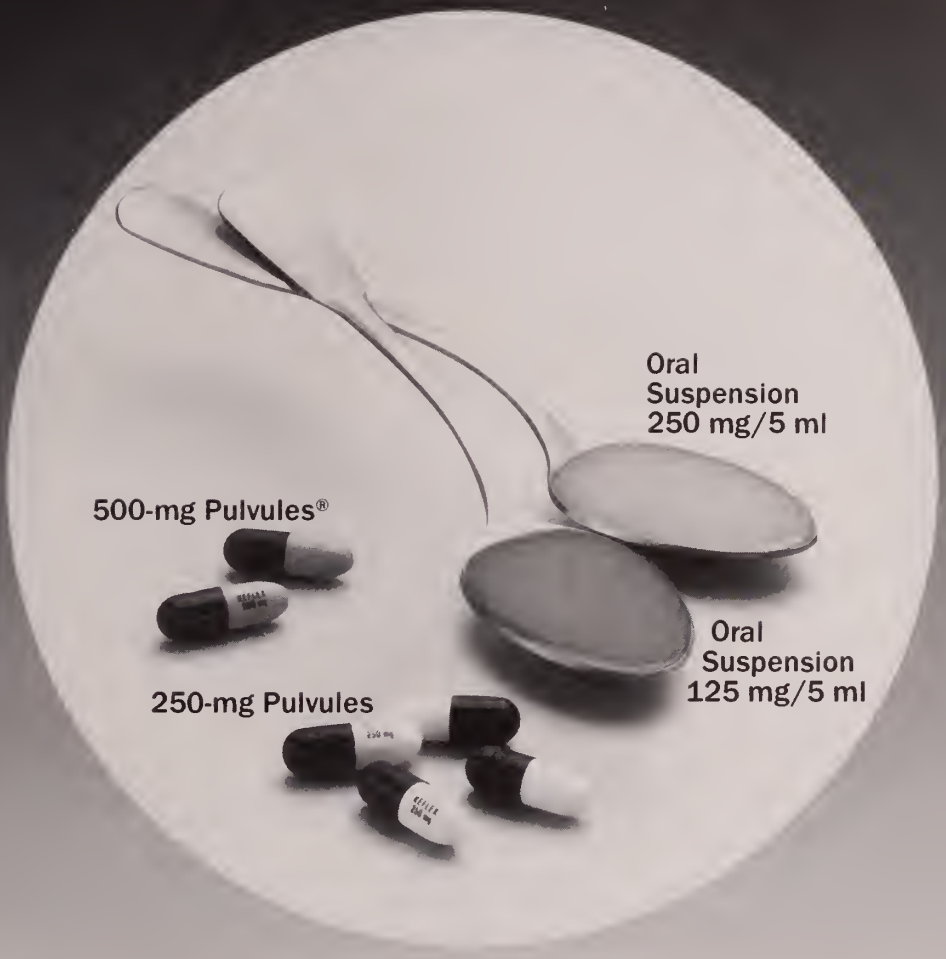

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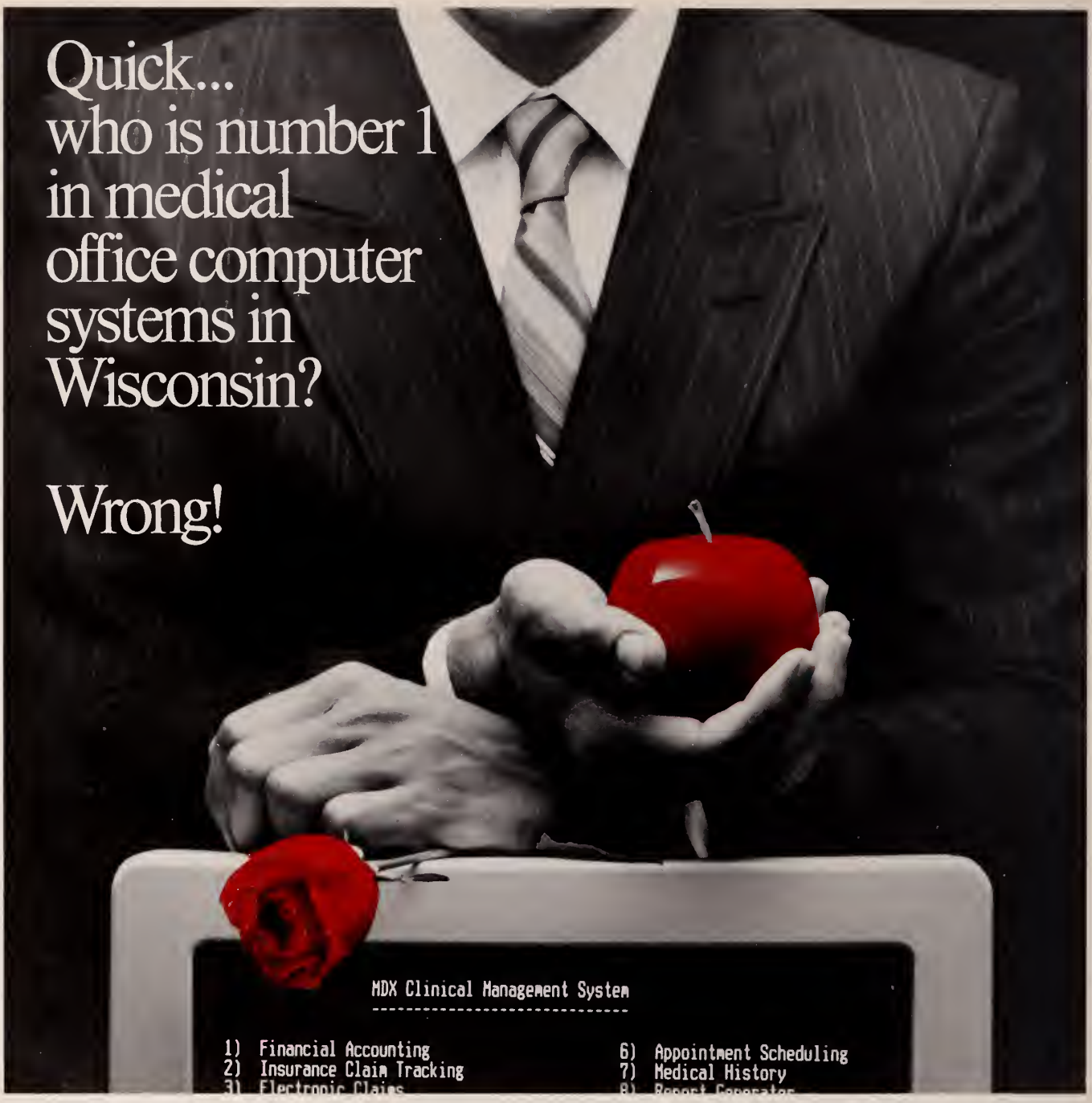

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Acute dissecting aneurysm of the ascending thoracic aorta causing obstruction and embolism of right pulmonary artery

Computerized tomography (CT), angiography, and clinical diagnoses

Byung (Robert) H Kim, MD and *Howard H Short, MD,* Racine, Wisconsin

ABSTRACT: *This is the first known case of acute dissecting aneurysm of the ascending thoracic aorta causing obstruction and embolism of the right pulmonary artery described by computerized tomographic (CT) examination. Followup digital and conventional angiography confirmed the CT findings. If one suspects this syndrome, CT study should be utilized as the initial diagnostic method before invasive angiography. Once the correct diagnosis is established, prompt surgical treatment should be considered. Antithrombolytic and anticoagulant treatment should be avoided.*

Key words: Ascending aorta; Dissecting aneurysm; Rupture; Pulmonary artery; Pulmonary embolus

Compression of the pulmonary artery by an aneurysm has been discussed frequently;[1-5] however, reported cases of compression of the pulmonary artery by an acute dissecting aneurysm are extremely rare.[6,7]

In the author's knowledge this is the first published case diagnosed by computerized tomographic (CT) examination.

The purpose of this report is to further the awareness of the syndrome and the possible utilization of CT study as a noninvasive modality for the initial diagnostic method.

Antithrombolytic and anticoagulant agents are contraindicated and should be avoided in the treatment of pulmonary embolism caused by an acute dissecting aneurysm of the thoracic aorta.

Case report. A 64-year-old male was admitted on Dec 7, 1983 with an onset of epigastric and lower midsternal chest pain. The patient had been asymptomatic until the day prior to admission when he developed a short episode of acute epigastric and retrosternal pain associated with shortness of breath. This pain spontaneously abated only to return the day of admission, precipitating the Emergency Room visit. No diaphoresis was noted, but marked shortness of breath was reported. There was no radiation of chest pain and no other associated symptoms.

During the Emergency Room visit, epigastric and chest discomfort persisted; however, the discomfort became less intense and the vital signs remained stable. An admission electrocardiogram showed inferior wall myocardial infarction, age undetermined.

The patient had a history of diverticulosis and Crohn's disease. Coronary artery disease had been documented in 1975 when a coronary angiogram demonstrated multiple vessel disease. Coronary artery surgery with two-vessel bypass had been accomplished in 1975.

Physical examination revealed a well-developed, well-nourished white male in no acute distress but with epigastric discomfort. Vital signs were stable without tachycardia or hypertension. Examination of the head and neck revealed no abnormalities. No venous distention or absent arterial pulsations were noted. The chest was clear to auscultation and percussion. Cardiac examination was normal without murmurs, rubs, or gallops. Peripheral pulses were all normal. Neurological examination showed no abnormalities.

Laboratory studies on admission showed some routine blood studies to be abnormal. A total white blood cell count was 19,600 per cu mm but with normal differential. The hematocrit reading was 46.3% and the hemoglobin level was 15.4 gm/dl. Abnormal blood chemistries on admission included a blood sugar of 187 mg/dl and creatinine of 1.6 mg/dl. No other abnormality was noted on laboratory study.

On admission the chest radiograph revealed an area of infiltration in the right base which was not seen on a radiograph from 1980. No other abnormalities were noted. A lung scan obtained the day of admission demonstrated diminution of perfusion of the right lower lung field, etiology undetermined. The CT

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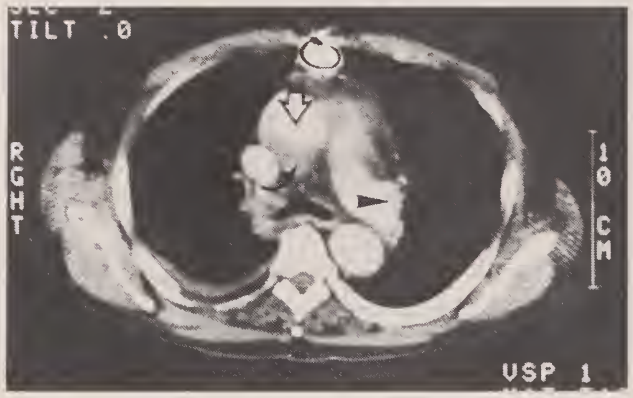

Figure 1—*Computerized tomographic (CT) scan of the level of the left pulmonary artery. The left pulmonary artery (black arrowhead) is patent demonstrating good contrast opacification. The dissecting aneurysm (curved arrow) arising from posterior wall of aortic root (white arrow) is clearly identified.*

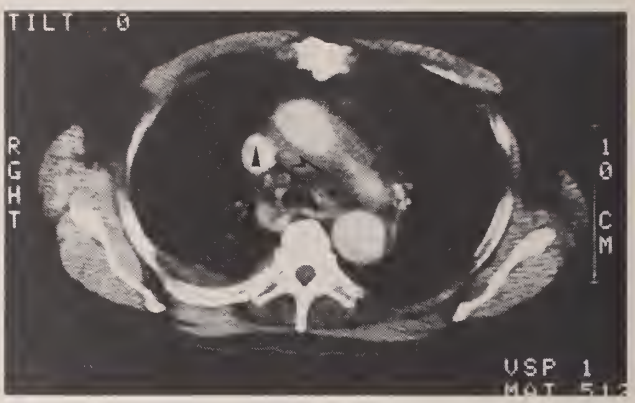

Figure 2—*CT scan at level of the aortopulmonary window. The superior vena cava (black arrowhead) is compressed along its medial and anterior wall by the dissecting aneurysm of the ascending aorta. Hemorrhage (white arrow) into aortopulmonary window is obvious.*

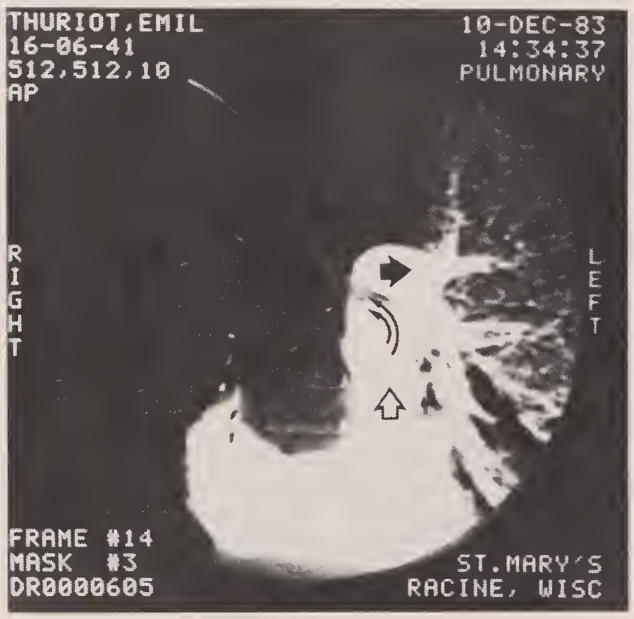

Figure 3—*Digital subtraction angiography with contrast injection was made at right atrium. Complete obstruction at origin of the right pulmonary artery (curved arrows) is identified. The pulmonary trunk (white arrow) and left pulmonary artery (black arrow) are patent.*

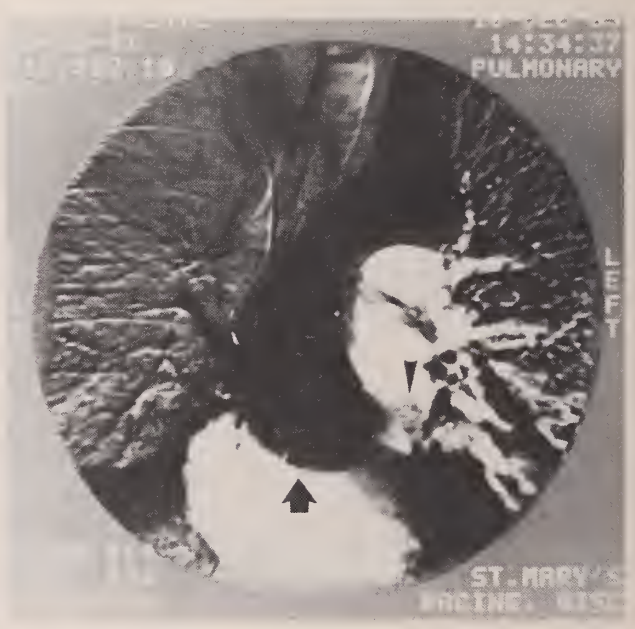

Figure 4—*Digital subtraction angiography with delayed image subtraction. Contrast filled ascending aorta (black arrow) delineates its position to relate pulmonary outflow track. A compression at proximal pulmonary trunk (arrowhead) is evident.*

scan of the chest (Figs 1 & 2) on Dec 8, 1983 showed right lower lobe infiltration with compression of the superior vena cava by a mass extending from the posterior supra-aortic portion, and occupying the subcarinal portion of the mediastinum. Dissecting aortic aneurysm of the ascending aorta with hemorrhage into the mediastinum was considered. The difficulty encountered was to differentiate the above from a possible superimposing mediastinal tumor. A digital subtraction angiographic (DSA) study of the chest (Figs 3 & 4) was accomplished on Dec 10, 1983 showing complete occlusion of the right pulmonary artery at the proximal segment. A repeat lung scan on Dec 13, 1983 showed complete absence of perfusion of the right lung. Because of the admitting electrocardiogram, the patient was initially treated in the Emergency Room with 500,000 intravenous units of streptokinase. After reviewing the outpatient electrocardiogram, it was felt that further streptokinase therapy was not indicated; however, intravenous heparin was continued

Figure 5—*CT scan at level of carina. Further hemorrhage posterior to aortic root (black arrowhead) and pulmonary trunk is recognized where pulmonary trunk is compressed along its posterior wall (curved black arrows) by the hematoma.*

through the early portion of the hospitalization. After demonstrating complete occlusion of the right pulmonary artery with the impression of a massive pulmonary embolus, the patient underwent twelve hours of intravenous therapy with urokinase.

A repeated lung scan did not demonstrate any improvement in the right lung perfusion after urokinase therapy. An abdominal CT scan showed no abnormality in the abdominal aorta except arteriosclerotic calcification. A repeat CT scan of the thorax (Fig 5) on Dec 16, 1983 showed minimal change. The size of the dissecting aneurysm was unchanged but CT suggested further hemorrhage into the mediastinal structure. Extensive thrombus of the pulmonary artery and right lower lobe infiltration was unchanged.

The patient was transferred to a University Center for definitive therapy. Examination at that time showed elevated venous pressure; however, vital signs remained stable. Preoperatively a supra-aortic angiogram was accomplished, documenting a dissecting aneurysm of the ascending aorta with further extravasation of contrast into what appeared to be the main body of the pulmonary artery.

The patient underwent a surgical exploration on Dec 19, 1983. During surgery, the pulmonary artery was discovered to be completely obstructed with a very large thrombus which was removed from the right pulmonary artery and the main pulmonary artery. The aortic wall dissection was repaired with anastomosis of the left anterior descending vein graft to the aortic wall graft. It was thought that the dissection had leaked and formed a large false aneurysm posterior to the main pulmonary artery and above the roof of the left atrium. There was also an apparent fistula between this false aneurysm and the pulmonary artery. Because of poor left ventricular function and a bleeding diathesis, the patient did not survive the immediate postoperative period.

A postmortem examination confirmed dissection of the ascending aorta with extension into the main pulmonary artery and hemorrhage in the right lung and mediastinum.

Discussion. Generally, a dissecting aneurysm of the ascending thoracic aorta results in a more serious and progressive clinical outcome than a saccular aneurysm.[4,6]

A nondissecting aneurysm may present clinical signs of chronic cor pulmonale, pulmonary artery stenosis, and aortic insufficiency,[4] but the aneurysm may also present varied manifestations depending upon whether the compressed structures are the blood vessels, nerves, esophagus, trachea, or cardiac chambers.[1-4]

Once either a dissecting or nondissecting aneurysm ruptures, the clinical outcome is serious. Rupture of the aneurysm into various adjacent structures is well documented.[5,8,9]

A dissecting aneurysm may form a pulmonary obstruction,[5,6,7,9,11] an aortopulmonary fistula,[5] and a superior vena cava syndrome.[10]

Prompt diagnosis and surgical treatment are imperative in these cases. CT examination is the initial diagnostic procedure of choice for differentiation from mediastinal tumor, and for evaluation of the extent of hemorrhage or thrombus in pulmonary vessels and mediastinal structures.

Angiography will confirm the obstruction and degree of stenosis of pulmonary vessels and superior vena cava.

Initially our patient appeared rather healthy, certainly not exhibiting a serious condition. Because of the patient's known cardiac disease and possible lung and mediastinal tumor, prompt surgical treatment was not accomplished. Others have observed that differentiation between an aneurysm and a paramediastinal tumor may be difficult or impossible to make using CT or arteriography[16,17] because of the possibility of a mediastinal tumor coexistent with a dissecting aneurysm.

The possibility of intravascular coagulopathy was not confirmed in our patient as it rarely oc-

curs.[12-15] In retrospect, gradual hemorrhage into the right pulmonary artery and mediastinum was further complicated by antithrombolytic and anticoagulant agents which should have been contraindicated.

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Visceral larva migrans

A case from the La Crosse area

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ABSTRACT. *Visceral larva migrans is a parasitic syndrome uncommonly seen in the midwestern United States. Ingestion of infective larva of the common dog roundworm,* Toxocara canis, *is the usual cause. History of pica and handling infected puppies should increase the suspicion of the illness. The hallmark of the illness is marked eosinophilia; however, the clinical presentation may be variable. The disorder is usually self-limited and benign but can lead to serious systemic complications. A case of visceral larva migrans seen from the La Crosse area is presented, and the illness is discussed.*

Key words: visceral larva migrans; *Toxocara canis;* Eosinophilia; Ocular toxocariasis; Thiabendazole

With the exception of pinworms, the population of Wisconsin has a low prevalence of parasitic worm infestations. This is not the case, however, of Wisconsin's domestic animal population. Therefore, in cases involving animal exposures, the possibility of accidental infestations with zoonotic worms should be considered by Wisconsin physicians.

Recently, we have reported two cases of cutaneous larva migrans[1] and we now report an unusual case of a woman with visceral larva migrans (VLM). This illness is caused by the migration in the somatic tissues of the body of the larval stage of animal ascaroid nematodes, usually *Toxocara canis,* the common dog roundworm.[2,3]

The term "visceral larva migrans" was introduced by Beaver and associates[4] in 1952. They reported three cases of a syndrome in children which included marked eosinophilia, hepatomegaly, and a history of pica. The larval nematode of *Toxocara canis* was identified in a liver biopsy of one of their patients. Since that time, more than 1900 cases have been reported throughout the world.

Prior to 1978, the diagnosis of VLM had been made on history, clinical symptoms, and nonspecific laboratory values.[5,6] Definitive diagnosis, visualizing the nematode larva in tissue, was infrequently made due to the difficulties of obtaining tissues and the low sensitivity of approximately 20% positive of percutaneous liver biopsies.[7] Fortunately, an enzyme-linked immunosorptive assay (Elisa) is now available and has been found to be 80% sensitive and 92% specific for antitoxocara antibody.[6] The following is a case report of a dog breeder who developed visceral larva migrans.

Case report. A 27-year-old Caucasian woman was first seen on Dec 1, 1983 with the chief complaint of sharp epigastric pain exacerbated by inspiratory efforts and eating. Similar complaints

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had occurred with increased flatulence and intermittent night sweats for six weeks prior to being hospitalized at a nearby hospital in November 1983. During that hospitalization, her examination was unremarkable, but a peripheral blood smear of 5,400 white blood cells per cu mm revealed 22% eosinophils. Stool for ova and parasites was negative. A barium enema disclosed a moderate-sized polypoid mass in the cecum, and an exploratory laparotomy revealed induration of the greater omentum with adhesions and edema involving the cecal area, and inflamed fallopian tubes.

Microscopic examination of the inflamed serosal tissue removed from the terminal ileum, cecum, and appendix showed the lamina propria to have been infiltrated with plasma cells and eosinophils. Treatment for acute salpingitis with penicillin G and amoxicillin for a total of ten days was given.

Two weeks after discharge she again developed abdominal pains very similar to the initial episode, and she was referred to our clinic. Further history revealed that she had been breeding dogs for the prior two years but had recently gone out of business due to a recurrent illness in the puppies, characterized by gastrointestinal dysfunction and a very high mortality rate.

The patient admitted to eating sandwiches which she laid on the kennel screens and often not washing her hands as she worked and ate.

Stool, obtained from one of her few remaining dogs, contained ova of hookworm, Coccidioides, and *Toxocara canis* (Fig 1). In addition, her Elisa test for Toxocara antibody was positive at a titer of 1:32.

The patient was feeling well by the time the diagnosis was confirmed, but three months later she returned with recurrent abdominal pains and eosinophilia of 14%. Therefore, thiabendazole at a dose of 25 mg per kg per day for seven days was initiated. Repeat Toxocara antibodies were 1:64. With persistence of symptoms, the thiabendazole was repeated at a dose of 25 mg per kg twice a day for seven days. After that course of therapy the patient has become asymptomatic and presently is doing well.

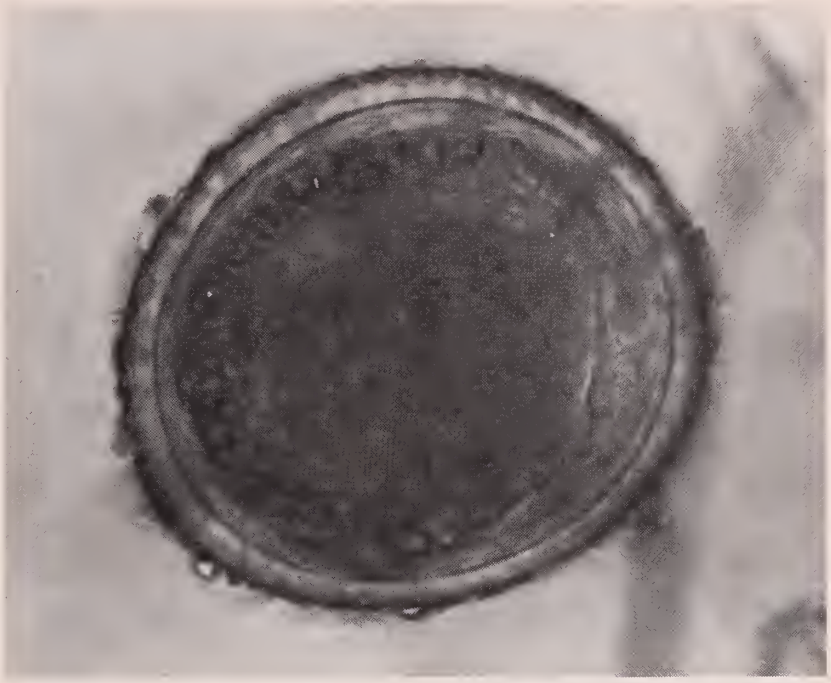

Figure 1—Toxocara canis *ovum from fecal concentrate of patient's dog (mag 450x).*

Discussion. The prevalence of antibodies tested by the Elisa method for *Toxocara canis* varies with geographic location. In the southeastern states, partly due to clay soils and a humid climate, the prevalence of positive titers is as high as 10% in adults and 23% in young children. However, in the North Central United States, VLM titers have been estimated to be less than 1% (Personal communication: Peter W Schantz Parasitic Diseases Division, Bureau of Epidemiology, Centers for Disease Control).

Children are at greatest risk for this infestation, especially those with a history of pica and close contact with puppies.[8,11] The infestation rate in puppies is greater than 80% and in adult dogs is about 20%. Infective eggs can be easily recovered from soil where dogs defecate frequently, and the eggs may remain viable for weeks to months depending upon climatic conditions.[9]

Puppies are frequently infested due to transplacental and translacteal dissemination of larva from the bitch. In the adult dog the larva migrate to somatic tissues and rarely complete their life cycle. The exception is in the pregnant bitch where, because of hormonal stimulation, the larva migrate transplacentally to complete their life cycle in the developing puppies. Once there, the larva spread through the liver and lungs where they migrate out of the alveolar capillaries into the alveolus and are cleared and swallowed. If there is a heavy infestation, puppies at three weeks of age, develop abdominal distress, and mortality is not infrequent. Once mature and

mated, the female worms may pass up to 20,000 eggs per day into the feces.[9]

If these eggs are ingested by man, they hatch in the proximal small intestine, penetrate into the portal system and are blood borne to all parts of the body, especially the liver, central nervous system, and occasionally the eye.[12]

The clinical manifestations and severity of the illness vary depending upon the number of invading larva, the organ that is involved, and the frequency of reinfection.[9] The spectrum of illness may run from asymptomatic to an acute febrile illness with peripheral eosinophilia, anorexia, malaise, and hepatomegaly. Other symptoms may include cough and wheezing, in which 50% will have pulmonary infiltrates on chest x-ray study. Encephalitis, meningitis, and epilepsy in children also have been associated with VLM.[13] Skin lesions include tender nodules of the palms and soles, erythema nodosum, purpura, fine papular rashes, and erythematous urticarial rashes of the abdomen and extremities. Other tissues that have been involved include pancreas, kidney, heart, bone, intestinal wall, and mesenteric lymph nodes.[10] Because of the infrequency of pica and the general improved personal hygiene in adults, the illness, as in our case, is usually more mild due to the decreased number of larva ingested. While VLM is rare in adults, workers in kennels have an increased risk of ascarid egg ingestion.[14,15]

A chronic form of visceral larva migrans known as ocular toxocariasis is usually seen in older children with the mean age being 7-8 years.[12] Common presenting symptoms include decreased visual acuity, strabismus, or eye pain. Rarely does severe endophthalmitis and retinal detachment occur. This lesion is difficult to distinguish clinically from retinoblastoma. In one pathologic review of eyes enucleated for presumed retinoblastoma, there were several instances of toxocariasis discovered.[10] In this form of the illness there is little peripheral eosinophilia and antibody titers tend to be lower.[12,16]

The diagnosis of visceral larva migrans cannot be made by examining stools for ova and parasites as the Toxocara species rarely complete their full life cycle in the human host. Thus, with the appropriate history, especially if coupled with a high eosinophilic count, VLM should be considered. The diagnosis can usually be confirmed by an enzyme-linked immunosorption assay, done at the Centers for Disease Control in Atlanta, Georgia.

Therapy is often unnecessary as this illness is usually benign and self-limited. However, once the diagnosis has been confirmed, the patient should be followed periodically, as individuals have developed the ocular form years after VLM.[9] In patients with life-threatening myocardial, central nervous system, or pulmonary involvement, or in those with active ocular lesions, corticosteroids are the treatment of choice. Diethylcarbamazine and thiabendazole, two antihelmenthic agents, have been used clinically and appear to relieve symptoms and shorten the course of illness.[17]

Preventive measures include eliminating the infestation in puppies and nursing bitches, keeping children away from infested puppies and contaminated soil, and good handwashing after handling puppies.[9,10]

Visceral larva migrans is an unusual infestation of people of Wisconsin, but one that Wisconsin physicians should be aware of due to the variable presentation and potential severity.

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Anorectal giant condyloma acuminatum

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ABSTRACT. *Giant condyloma acuminatum originating in the anorectum has been reported 12 times in the world's literature. Although benign histologically, these tumors have been reported to display aggressive local growth and frequently become nonresectable. Malignant transformation to a well-differentiated squamous cell carcinoma is common. We describe a single case of giant condyloma acuminatum beginning in the anal canal. The tumor measured 16 cm in diameter and caused incontinence by preventing apposition of the anal sphincter. Local wide resection with skin grafting resulted in a cure. The tumor was benign on histological examination. The surgeon confronted with an anorectal giant condyloma acuminatum should aggressively remove it. Local resection may be adequate, but if the tumor is advanced or involved in an abscess or fistula, abdominal perineal resection is indicated. Chemotherapy or radiotherapy has not been effective to date.*

Key words: Giant condyloma acuminatum; Anorectal tumor

Giant condyloma acuminatum is an uncommon verrucous lesion that predominantly occurs on the uncircumcised penis. It also has been described on the scrotum, vulva, vagina, perineum, and anorectum. The first case was described by Buschke in 1896 and, again, in 1925 by Buschke and Loewenstein.[1] The commonly used eponym is thus "Buschke-Loewenstein tumor." These tumors are known for their benign appearance on histological examination, but clinically they display malignant local growth and extension. Recurrences are noted frequently even after resection of all gross tumor. Metastatic spread to local or regional nodes does not occur. Occasionally transformation of giant condyloma has been observed with a microscopic appearance of squamous cell carcinoma and with a propensity to metastasize.

A single case of giant condyloma acuminata originating in anal canal is presented. Twelve previously reported cases from the world's literature are reviewed.

Case report. A 47-year-old man was evaluated because of a verrucous tumor in the perianal region (Fig 1). This tumor had first been recognized five years earlier as a small lesion of the anal canal. It had been treated several times with podophylline, but this was discontinued by the patient because of severe pain. Growth of the tumor had been most remarkable over the previous two years. The patient's lifestyle was severely restricted because of disability produced by the large mass. Cleansing of the area to control odor and tissue breakdown necessitated bathing after each bowel movement. The patient was also incontinent of stool because the tumor prevented apposition of the anal sphincter. No other symptoms relating to the gastrointestinal tract or genitourinary tract were present. The patient had a 60-pack-per-year history of smoking and consumed copious quantities of alcohol. He denied previous anal sexual intercourse or homosexual activity. He had no history of previous venereal disease.

The tumor measured 16 cm across, protruded 2 to 3 cm above the surrounding skin, and extended internally to the dentate line. Sphincter tone was decreased but proctoscopic examination was unremarkable beyond the tumor. Five condylomata up to 1.5 cm were present on the scrotum and in the right groin. Inguinal nodes were not enlarged. No other remarkable physical findings were noted.

The patient was prepared for surgery with a thorough two-day mechanical bowel preparation. The giant condyloma was excised with a 1-cm skin margin. Dissection through the subcutaneous plane was carried down through the anal canal and into the submucosal plane of the rectum. The distal rectal mucosa was transected just above the dentate line. No tumor was noted above this level. The rectal mucosa was transfixed at the dentate line, and the remaining defect was covered by a split thickness skin graft. Groin and scrotal tumors were also excised. The patient was medicinally constipated and kept in bed for five days before removal of the pressure dressings. The graft had taken adequately, and complete healing was noted over the next weeks. The patient continues to do well without evidence of

From the Department of Surgery, Marshfield Clinic, Marshfield. Publication support provided. Reprint requests to: R Lee Kolts, MD, Dept of Surgery, 1000 North Oak Ave, Marshfield, Wis 54449 (ph 715/387-5221). Copyright 1985 by the State Medical Society of Wisconsin.

Figure 1—*A giant condyloma acuminata surrounds and replaces the anal canal. The tumor measures 16 cm across. The patient is in the prone jackknife position.*

recurrent disease after six months. He is gradually regaining anal continence.

Discussion. Twelve cases of anorectal Buschke-Loewenstein tumors have been reported in the world's literature. Along with the current case they are summarized in Table 1. Patients' ages range from 32 to 73 years, the mean being 46 years. Ten of 13 patients were male. Patients were aware of the tumor an average of 7.5 years by the time of presentation, although the range is three months to 23 years. Generally the tumor is minimally symptomatic for the first several years. The most common presenting symptom is local pain (11 of 13 cases). This may be secondary to abscess formation,[2,7] local cellulitis, or fistula formation.[8,9] Patients also may present with complaints of abnormal defecation including incontinence[3] or constipation.[4,5] This is a result of tumor interference with the sphincter mechanism or obstruction by the tumor mass. The main complaint in our patient was his inability to maintain personal hygiene because of the continuous contact of stool with the verrucose surface. All patients are aware of an enormous mass.

Giant condylomata acuminatum is considered a variant of common condyloma acuminata and is thought to be passed by venereal contact. Indeed the causative agent is thought to be the human papillomavirus.[10] Of the anorectal cases only one has been reported in a patient with a history of homosexual activity.[9] Such activity is denied in two other reports[11] (current case), and a history of other venereal disease is noted in one case.[3] The nine other reports do not mention a sexual history.

The typical microscopic appearance of giant condyloma acuminatum is similar to common condyloma acuminata with acanthotic squamous epithelium, hyperkeratosis, and papillomatosis. Virus-like particles may be seen by electron microscopy.[9] Malignant transformation frequently occurs in condyloma. This was noted in five (38%) of the 13 cases.[2,4,9,12,13] These malignancies are squamous cell carcinomas, and they display local invasive and metastatic behavior.

The clinical behavior of the

Table 1—*anorectal giant condyloma acuminata*

Reference	*Age/Sex*	*Symptom Duration*	*Treatment*	*Complications*	*Results*
Siegel[2]	37/M	10 years	1. Excision and fistulotomy 2. Abdominal perineal resection, pelvic lymphadenectomy	Multiple recurrences Malignant transformation	Cure (13 months)
Knoblich[3]	50/M	1 year	1. Biopsy 2. Colostomy	Abscess Intraabdominal perforation	Death
Burns[13]	49/M	23 years	1. Excisions—(multiple) 2. Abdominal perineal resection 3. Radiotherapy	Abscess Malignant transformation	Cure (7 months)
Shah[8]	32/F	14 years	1. Podophyllin 2. Colostomy, resection 3. Radiotherapy 4. Abdominal perineal resection 5. Chemotherapy	Multiple recurrences Pelvic extension	Death
Shah[8]	73/F	4 years	1. Resection refused 2. Radiotherapy	Recurrence Anorectal stricture	Progressive tumor growth
Drut[4]	39/M	12 years	1. Resection (2) 2. Drain abscess 3. Colostomy 4. Abdominal perineal resection	Local spread Abscess Malignant transformation	Inadequate time
Sturm[12]	49/M	6 years	1. Local resection 2. Resection 3. Abdominal perineal resection	Extensive spread Multiple recurrences Malignant transformation	Recurrent squamous cell carcinoma
Lock[5]	45/F	1 year	1. Colostomy, biopsy 2. Abdominal perineal resection, hysterectomy	Abscess Rectovaginal fistula	Cure (8 months)
South[6]	38/M	1 year	1. Multiple resections 2. Colostomy 3. Abdominal perineal resection 4. Chemotherapy 5. Radiotherapy	Extensive pelvic invasion	Death
Elliot[7]	39/M	15 years	1. Resection, colostomy 2. Drain abscess 3. Chemotherapy 4. Radiotherapy	Abscess Pelvic extension Recurrence	Death
Alexander[11]	35/M	4 years	Resection	None	Cure (3 months)
Ejeckman[9]	61/M	3 months	Resection	Malignant transformation	Cure (6 months)
Current Case	47/M	6 years	Resection, skin graft	None	Cure (6 months)

giant condyloma acuminatum, even in the absence of a malignant pathology, displays local malignant characteristics. Four deaths have been reported secondary to extensive local extension of anorectal tumors.[3,6,7,8] Each of these was benign microscopically. Two other cases had extensive recurrent (nonresectable) disease at the time of reporting.[8,12] Spread to regional nodes or distant sites has not been reported without malignant transformation. Local invasion and local recurrences are frequent and may be severe. Extension into the pelvis may occur if it is not prevented by early resection. These tumors frequently produce fistulae and anal abscesses. Once the tumor is found in association with an abscess or fistula, it is difficult to eliminate and usually requires abdominal perineal resection. This was performed in seven of 13 cases. If the tumor recurs, the recurrences generally are noted within weeks of resection but have been reported as late as seven months.[12]

Giant condyloma is occasionally treated by nonsurgical means. Podophyllin suspension has been shown to be ineffective and can produce changes in cell

morphology suggesting squamous cell carcinoma. Various other chemotherapeutic regimens have been tried in three cases with no apparent success.[6,8] Radiotherapy also was used in four patients. It produced some shrinkage of tumor and relief of symptoms in two cases[7,8] and had no effect in one case.[6] The fourth patient received cobalt-60 treatment postoperatively, and no recurrent tumor was noted after seven months.[13] The roles of both chemotherapy and radiotherapy remain to be defined, neither showing much promise to date. However, immunotherapy has been successfully used in several cases of giant condyloma acuminatum and appears to have promise.[14,15]

The current treatment of choice is surgical. The surgeon should be aggressive in removing the entire tumor; and when possible, this should be done at the first operation. Local resection may be adequate. This may be performed using skin grafts or allowing the site to heal by secondary intention. In the presence of a fistula or abscess, local resection and drainage of the abscess has not been successful. This is because of local spread into the fistula tract or abscess cavity. In these situations abdominal peroneal resection is generally indicated. Lymph node dissections are not of value but may be indicated following malignant transformation. Following the patient at frequent intervals for up to a year after surgery is essential so that local recurrences can be expeditiously removed.

Summary. A case report of a patient with a giant condyloma acuminata originating in the anal canal is presented and the current literature is reviewed. This totals 13 cases in which the tumor began in the anorectum. Anorectal giant condylomata are variants of the common condyloma acuminata. They are thought to be spread by venereal contact. They appear benign on pathological examination but behave with remarkable local aggression. These tumors frequently undergo malignant transformation; however, metastatic spread is not a characteristic. Current treatment is aggressive surgical resection, and close postoperative followup. Local recurrent tumor is frequently noted in spite of previous resection of all gross tumor. Immunotherapy may become a therapeutic possibility in the future.

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ABSTRACT

Microscopically controlled surgical treatment for squamous cell carcinoma of the lower lip

FREDERIC E MOHS, MD; STEPHEN N SNOW, MD, Chemosurgery Clinic, Department of Surgery, University of Wisconsin Hospital and Clinics, Madison, Wis: *Surg Gynec Obst* 1985 [Jan];160:37-41

The total microscopic control of the excision of squamous cell carcinoma of the lower lip that is achieved by excising the underside of each layer in the microscope by the systematic use of frozen sections provides two main benefits: [1] assurance of complete eradication of the cancer including the clinically unpredictable slender outgrowths that often extend well beyond the clinically apparent borders, and [2] maximal sparing of adjacent normal tissues. During the 40 years from 1936 to 1976 microscopically controlled surgery was used in the treatment of 1448 patients with a 5-year cure rate of 94.2 percent. Because of the sparing of normal tissues many of the lesions are amenable to anterior-posterior closure; but if the cancer is very deep, the wound is converted into a wedge which can be sutured vertically with good cosmetic and functional results. ■

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SMS Board encourages negotiation in ER services

In response to House of Delegates Resolution 22 dealing with emergency department reimbursement for treatment of HMO/AFDC patients, the Board at its August 24 meeting went on record opposing any changes in S.146.301 *Wis Stats* regarding prohibitions on refusals to treat the sick or injured by hospital emergency services.

The Board also noted that the reimbursement issue has been resolved in the short term by a DHSS interpretative bulletin of June 26 and long term because Requests for Proposals (RFPs) from HMOs wishing to contract with the State to enroll the AFDC population for 1986 will require memorandums of understanding between HMOs and ER providers regarding payment conditions.

The SMS Board also encouraged DHSS, HMOs, and emergency room physicians to resolve their differences through negotiation.

Other actions of the Board

• Directed the Physicians Alliance Commission to develop a plan of action to have SMS monitor and collate examples of denials of fair and equal access to care by Collective Provider organizations, third party payors, and governmental insurers in Wisconsin. This action is in response to House Resolution 21, which requested the Board to study and possibly implement an appeals and monitoring system for patients and physician.

• Voiced its opposition to US Senate Bill 70, which would make heroin available for cancer pain relief. The Board noted that after many studies, heroin has not demonstrated an advantage over morphine, methadone, and other pain medications, but it does present diversionary complications. The SMS position on SB 70 will be communicated to the Wisconsin Congressional Delegation, as well as the AMA.

• Received an update on the activities of the Medical Liability Task Force from its chairman, William Listwan, MD. Doctor Listwan noted that of immediate concern is a review of the panel system in Wisconsin and an ongoing media campaign dealing with the liability issue. The Task Force also will address a support system for physicians who have been sued and their families, and alternatives to the tort system. The Board also appointed the following physicians to the Medical Liability Task Force: Lucille Glicklich, MD, Milwaukee; Paul Fox, MD, Waukesha; Matthew Meyer, MD, Pewaukee; and Edward Zupanc, MD, Monroe.

• Noted that SMS membership currently stands at 5,990, an increase of nearly 10% over a year ago. Full dues-paying members increased by 8%, while candidate membership grew by 23% to 400.■

SMS to seek small area variation analysis

As a result of Board of Directors action August 24, SMS will seek to become a demonstration project as part of an overall AMA program to evaluate geographic variations in the utilization of healthcare services.

This effort will support an AMA policy directive to show the capacity of private sector initiatives to manage utilization patterns in a cost effective, quality-conscious manner. It will be developed as part of the Society's Task Force on Data Collection and Use.■

SMS Services, Inc Board highlights

The Board of Directors of the SMS Services, Inc met August 24 at SMS Offices in Madison. The following officers were elected to succeed themselves for the next year:

William P Crowley Jr, MD, Madison, President
John P Mullooly, MD, Milwaukee, Vice President
Earl R Thayer, Madison Secretary
Richard W Edwards, MD, Richland Center, Treasurer

A financial report through July 31, 1985 showed the following:

Total assets	$701,733
Shareholders equity	184,054
Net profit after provision for State and Federal taxes	62,532

The State Medical Society is the sole shareholder of SMS Services, Inc.

An insurance agency report showed that 2,676 Society members have enrolled in The Professionals—professional liability insurance plan. Since July 1984 over 400 new Society members can be tracked directly to this

continued on next page

SMS Services, Inc endorses WC program

Following an extensive study, SMS Services, Inc has endorsed the Dividend Program for workers' compensation insurance offered by the Dodson Insurance Group of Kansas City, Missouri.

The Dodson Plan was chosen because Dodson has 30 years of experience in providing successful workers' compensation

Continued from preceding page

plan. The report also noted that other casualty lines underwritten by The Professionals are anticipated to be available by year end. The report also stated that the Society's group health plan continues to grow. Efforts are being made to substantially increase the group size to further spread the risk and make it an even better membership benefit.

The Board announced that it has endorsed the Dividend Program for workers' compensation insurance offered by the Dodson Insurance Group of Kansas City, Mo. Letters to all Society members were mailed in August, and some physicians already have enrolled. A separate article on this program appears elsewhere in this issue.■

plans to more than 200 associations in 50 classes of business including a number of medical associations across the country, its financial size and stability, and its very attractive dividend program, stated LeRoy A Johnson, executive vice president of SMS Services, Inc.

In Wisconsin workers' compensation premiums are established by the State, thus premiums from all insurance companies are the same. The dividends paid, however, determine a participant's true cost. Dividends in the Dodson Plan have ranged from 30% to more than 40% per year in many cases. As an example, physicians in Minnesota who participate in the Dodson Plan have received dividends averaging 36.47% since 1972. Dividends in this Plan are paid promptly after policies expire on October 1 each year based on claim costs. For those who are interested Dodson also offers various premium payment plans without fees of any kind.

Policies under the Dodson Plan are issued by Casualty Reciprocal Exchange, a member of the Dodson Insurance Group since 1912, and a recognized leader in providing workers' compensation insurance, having an A.M. Best group rating of A+ (Excellent) and a financial size category of XIII.

Mr Johnson also noted that although the SMS Services, Inc has endorsed the Dodson Group, the Dividend Program is handled directly by the Dodson Group and not through SMS Services, Inc. Members interested in more information should call Dodson toll-free at 800-821-3760 and ask for Direct Sales.■

Discount prices on typewriters and copiers

SMS Services, Inc has negotiated an agreement with Modern Business Machines in Madison to provide SMS members with a discount on IBM Wheelwriter 3 Electronic and IBM Wheelwriter Selectronic typewriters (7K memory), with options. Also available is a discount on the Xerox Model 1020 and 1025 copiers with options.

For further information contact Noreen Krueger at SMS Offices in Madison at 608-257-6781 or 1-800-362-9080, extension 141.

SMS Leadership Conference October 26 in Appleton

Representatives from all facets of organized medicine in Wisconsin will convene October 26 for an all-day Leadership Conference at the Paper Valley Inn, Appleton.

Two major speakers are scheduled to discuss where medicine is headed—Uwe Reinhardt, Princeton Professor of Economics, and Eugene Mayberry, MD, chairman of the Board of the Mayo Foundation.

Special invitations have been extended to officers, delegates, directors, county medical society officers, scientific specialty section officers, specialty society officers, and all members of commissions and committees. The entire membership, of course, is welcome to attend.■

SMS to study health data collection

The Board of Directors at its meeting August 24 authorized a special task force to examine the issue of the collection, analysis, and release of Wisconsin healthcare data, including hospital and physician specific information.

The study is expected to produce recommendations for SMS policy on how such data should be developed, pooled, and used. Many commercial as well as governmental ventures are moving into Wisconsin with proposals to provide such data to virtually any private or public buyers.

SMS Board chairman, Darold A Treffert, MD, will name the task force shortly.■

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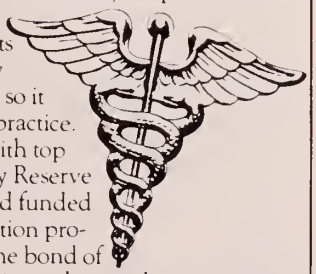

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SMS helps sponsor sexual abuse workshop

A two-day workshop on *Sexual Abuse in Therapy: A Multidisciplinary Approach to Recognition, Treatment, and Prevention* was held September 13–14 at the Howard Johnson Motor Lodge in Milwaukee. The State Medical Society assisted in sponsorship of the workshop to provide education on the nature of the problem and assistance in developing solutions. Workshop topics focused on sexual involvement in therapy, treatment of victim survivors in individual and group therapy, legislative and legal actions, and treatment of the assaultive/seductive therapists.■

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ARMY MEDICINE. BE ALL YOU CAN BE.

"Your doctor's new suit could cost *you* a barrel"

That's the title of the latest newspaper ad published by the State Medical Society in its campaign to bring public attention to the medical liability issue. This second ad ran in the August 25 Sunday editions of eight major dailies around the state. It emphasized the escalating costs of liability insurance and the fact that only 20% to 30% of premium dollars will ever get to the injured patient. A copy of the ad appears on the opposite page. Still another ad is planned for publication to emphasize the growing impact of malpractice on healthcare costs and how they affect the availability of quality healthcare. County medical societies are urged to consider sponsoring these same ads in their local papers. Contact Ron Henrichs, director of membership/communications, at SMS Offices in Madison.■

Financial Planning Seminar set

In cooperation with Reinhart, Boerner, Van Dueuren, Norris & Rieselbach, SC, Attorneys at Law, the SMS Services, Inc will hold its annual Personal Financial Planning Seminar Thursday, October 3, at the Marriott Inn in Brookfield. The program will include topics on:

—Financial and Estate Planning After 1984 Legislation (including marital property law)
—Maximizing After Tax Income
—Qualified Retirement Plans
—Structure of Professional Practice.

As in past years, the program will be presented by the same highly qualified faculty. A registration form appears elsewhere in this issue. Lunch is included in the registration fee.■

Your doctor's new suit could cost *you* a barrel.

Today it's not unusual at all for malpractice awards to reach one, two, even nine million dollars.

And where does the money to pay these awards come from? *Your* pocket! The cost of malpractice insurance adds as much as $3 to each visit to a physician, $5 a day to the average hospital bill, and up to $300 to the cost of some births.

To cope with increasing numbers of suits and awards, malpractice insurance premiums for physicians tripled in the last five years. And this increase in premiums is passed on to you every time you set foot in a doctor's office, get into a hospital bed or have surgery.

But what doctors find most distressing is knowing that only 20 to 30% of the premium dollars will ever get to the injured patient. The vast majority of this money goes to insurance companies, litigation costs and attorneys.

Doctors are working to relieve the problem by imposing stricter sanctions on doctors who don't meet accepted standards.

In the legislature, State Medical Society members are also supporting a bill to assure patients of adequate compensation in the unfortunate event that true malpractice does occur and to lower the cost of malpractice insurance.

Talk to your legislator and tell him/her you want something done to help cure the malpractice problem in Wisconsin and write us for a free, Healthwatch brochure.

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The above ad is reprinted from the August 25 Sunday editions of the following newspapers: *The Milwaukee Journal, The Wisconsin State Journal, Appleton Post-Crescent, Racine Journal Times, The St Paul Pioneer Press-Dispatch, Green Bay Press-Gazette, La Crosse Tribune,* and *Duluth News Tribune and Herald.* See accompanying story on opposite page.

Nominations sought for SMS offices

The House of Delegates Nominating Committee will meet on Saturday, October 26, in conjunction with the SMS Leadership Conference to be held at the Paper Valley Inn, Appleton. The committee will receive nominations and interview candidates for the following positions:

—President-elect for 1986-87

—Vice Speaker of the House of Delegates for 1986-88 to succeed Vernon M Griffin, MD, Mauston (completing second two-year term)

—AMA Delegates for calendar years 1987 and 1988 to succeed:

John K Scott, MD, Madison
Patricia J Stuff, MD, Bonduel
DeLore Williams, MD, West Allis

—AMA Alternate Delegates for calendar years 1987 and 1988 to succeed:

Cyril M Hetsko, MD, Madison
John P Mullooly, MD, Milwaukee
John D Riesch, MD, Menomonee Falls

All of the incumbents are eligible for reelection.

Members of the Nominating Committee, elected by the House on April 25, are as follows:

DISTRICT 1—Jerome W Fons Jr, MD, Cudahy; Robert F Purtell Jr, MD, Milwaukee; John D Riesch, MD, Menomonee Falls; and Raymond E Skupniewicz, MD, Racine.

DISTRICT 2—Sandra Osborn, MD, Madison; and James J Tydrich, MD, Richland Center.

DISTRICT 3—Stephen B Webster, MD, La Crosse (chairman).

DISTRICT 4—John E Thompson, MD, Nekoosa (secretary).

DISTRICT 5—Kenneth M Viste Jr, MD, Oshkosh.

DISTRICT 6—Rolf S Lulloff, MD, Green Bay.

DISTRICT 7—Merne W Asplund, MD, Bloomer.

DISTRICT 8—Charles R Longstreth, MD, Ashland.

SPECIALTY SECTIONS—Philip J Dougherty, MD, Menomonee Falls.

(Note there are some changes from the committee as reported in the June BLUE BOOK issue: In District 6 Doctor Lulloff has replaced Robert T Schmidt, MD of Green Bay and in District 8 Doctor Longstreth has replaced Joseph M Jauquet, MD of Ashland.)

SMS members wishing to communicate with the Nominating Committee may address letters to the Committee at SMS Offices, PO Box 1109, Madison, WI 53701.■

CES Foundation Annual Board meeting held

At the Annual Meeting of the Charitable, Educational and Scientific Foundation, held August 24 at SMS Offices in Madison, the Board of Trustees took the following actions:

• Elected the following officers:

President—Robert T Cooney, MD, Portage; Vice President—Stephen B Webster, MD, La Crosse; and Treasurer—Richard W Edwards, MD, Richland Center.

• Approved a budget of $10,000 for the 1985 Wisconsin Workshop on Health ($3,000 from SMS, $5,000 from SMS Auxiliary, and $2,000 from CESF). The program for senior high students will be held Wednesday, October 2, in Oshkosh. The program will focus on teenage sexuality.

• Approved an operating budget for the Fort Crawford Medical Museum.

• Received a $1,000 donation to the *Beaumont 500 Club* from the 1985 Staff of the State Medical Society.

• Approved a request from the Green Lake/Waushara County Medical Society for two $500 grants to be given to two high school teachers in Wisconsin for development of innovative science curriculum in the schools. Also approved for the program was an allotment of up to $500 to be used for materials. The CES Foundation will then be a co-sponsor of the program.

• Approved formation of an Artifact Review Committee to be named by the President, to review existing and new gifts of a nonmonetary type, while determining a course of action to be presented to the Finance Committee and the Board.

• Approved formation of a Finance Committee comprised of: Robert T Cooney, MD, Portage, President; Richard W Edwards, MD, Richland Center, Treasurer; and Ronald W Lewis, Madison, Nonmedical Trustee.

• Voted to increase voluntary contributions to the Foundation by incremental $5.00 increases over a period of three years (1986 voluntary contributions will then be $25.00).

• Requested SMS to raise to $25.00, the amount which is donated for memorials for deceased members. Currently the memoriams are $15.00 per member.

• Voted to encourage SMS to provide certain administrative services to the Foundation on an annual basis. A proposal will be forwarded to the SMS Finance Committee.■

Harold Wagner, MD, 66, Kenosha, died Mar 20, 1984 in Kenosha. Born July 3, 1917 in Chicago, IL, Doctor Wagner graduated from the University of Illinois School of Medicine in 1950 and served his residency at Cook County Hospital in Chicago. He served in the United States Air Force from 1942-1946 during World War II. Doctor Wagner was the Director of Laboratories at St Catherine's Hospital in Kenosha and also served as the Kenosha County coroner. He was a member of the Kenosha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow and two children.

Raymond G Yost, MD, 81, Manitowoc, died May 9, 1985 in Boynton Beach, Florida. Born Jan 18, 1904 in Oshkosh, Doctor Yost graduated from Marquette University School of Medicine in 1934 and served his internship at Milwaukee County General Hospital. Doctor Yost began his medical practice in Manitowoc in 1935 and was a member of the medical staff of Holy Family and Memorial hospitals. He was a member of the American Academy of Family Physicians, International College of Surgeons, and a member of the American Society of Abdominal Surgeons. He also was a member of the Manitowoc County Medical Society, a member of the "50 Year Club" of the State Medical Society of Wisconsin, and a member of the American Medical Association. Surviving are his widow, Marie; and two daughters, Madelyn Mlada, Sheboygan, and Kathie Schipper of Green Bay.

Lawrence G Patterson, MD, 81, Sun Lakes, Ariz, died May 24, 1985 in Chandler, Ariz. Born Jan 7, 1904 in Tippecanoe, Ohio, Doctor Patterson graduated from Ohio State University School of Medicine in 1931 and served his internship in Springfield, Ohio. He practiced medicine in Waupaca for 19 years. Doctor Patterson retired in 1971. Surviving are his widow, Jeanette; one daughter, Sara Jane Berge; and two sons, Frederick and Lawrence Jr.

Adolph M Hutter Sr, MD, 79, Madison, died June 19, 1985 in Janesville. Born Nov 26, 1905 in Fond du Lac, Doctor Hutter graduated from the University of Wisconsin Medical School, Madison. He served his residency at Research Hospital, Kansas City, Missouri, and completed his residency at University Hospital and Clinics in Madison. He was in private practice in Fond du lac from 1933 until his retirement in 1979. He served as chief-of-staff at St Agnes Hospital, Fond du Lac, was a member of the executive committee and also served as president of the Fond du Lac County Medical Society. He was a past president of the Wisconsin Heart Association and served as chairman of the Committee on Aging of the State Medical Society of Wisconsin. He was a veteran of World War II serving in the United States Navy. He was a member of the Dane County Medical Society, the "50 Year Club" of the State Medical Society of Wisconsin, and a member of the American Medical Association. Surviving are his widow, Janet; one son, Adolph M Hutter Jr, MD of Needham, Mass; and one daughter, Mrs Paul M Ryan of Janesville.

Richard B Smith, MD, 42, Brookfield, died July 1, 1985 near Kenora, Ontario. Born Feb 19, 1943 in Milwaukee, Doctor Smith graduated from Marquette University School of Medicine and served his internship at Mt Sinai Hospital, Milwaukee. His residency was completed at Milwaukee County Hospital. A radiologist on the medical staff of Good Samaritan Medical Center, Milwaukee, Doctor Smith was a member of the American College of Radiologists and the Roentgen Ray Society. Surviving is his mother of Bayside.

Marion K Ledbetter, MD, Tulsa, Okla, died July 3, 1985 in Tulsa. Born Nov 16, 1921 in Clarksville, Tex, Doctor Ledbetter graduated from the University of Oklahoma School of Medicine and served his internship at Methodist Hospital, Indianapolis, Ind. Doctor Ledbetter practiced medicine in Madison where he was on the medical staff of St Marys Hospital Medical Center and also on the faculty of the University of Wisconsin Medical School. He moved to Tulsa in 1979 and was vice chairman and professor of pediatrics at the Oral Roberts University School of Medicine and also chief of pediatric cardiology at City of Faith Medical Research Center at the time of his death. Surviving are his widow, Dixie; three sons, Marion, Madison; Jeffrey, Seattle, Wash; and Russell, Tulsa; three daughters, Denise, Seattle, Wash; Robin, Madison, and Laura of Tampa, Fla.

Earl A Hatleberg, MD, 79, Chippewa Falls, died July 11, 1985 in Chippewa Falls. Born Feb 6, 1906, Doctor Hatleberg graduated from Rush Medical College, Chicago, and served his internship at Swedish Covenant Hospital in Chicago. His residency was completed at the Monroe Michigan Clinic Hospital. Doctor Hatleberg practiced in Rice Lake until 1941 when he entered the United States Navy serving until 1946. He practiced in Chippewa Falls until his retirement in 1976. He was a member of the Chippewa County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.■

BLUE BOOK UPDATE

On page 124 of the June BLUE BOOK under Managing Committee, Statewide Impaired Physician Program, the new committee should read:

Gerald C Kempthorne, MD, Spring Green, Chrmn
Roland E Herrington, MD, Milwaukee
Fred H Koenecke Jr, MD, Madison
Arthur G Norris, MD, Milwaukee
Michael M Miller, MD, Eau Claire
William P McDaniel, MD, Milwaukee

On page 134 under Specialty Society officers, the Wisconsin Society of Plastic Surgeons is as follows:

President . . . . . John E Hamacher, MD (Aug 1986)
20 S Park St, Madison 53715
Secretary-Treasurer . . . . . Sharon L Elias, MD (Aug 1986)
400 W Silver Spring Dr, Milwaukee 53217

Also, on page 132 under the Section on Plastic Surgery the chairman and secretary are Doctors Hamacher and Elias, respectively.

On page 122 under the Commission on Continuing Medical Education, James T Houlihan MD, Woodruff, has resigned.

On page 132 the Section on Therapeutic Radiology has replaced the Section on Radiation Oncology; therefore, the section officers under Radiation Oncology should be listed under the Section on Therapeutic Radiology, even though the specialty society name is Wisconsin Society of Radiation Oncologists.■

CES Foundation

of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the months of June and July 1985.

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J-5491 June 1985

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Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

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In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

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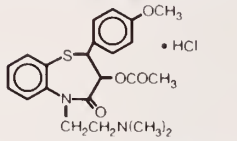
DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina. CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LOH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LOH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LO_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LO_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NOC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NOC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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Medicare participating physician issue update

With time running out on the October 1 deadline for physicians to make their Medicare determinations on whether to be 'participating' or 'non-participating' under the second year of the Deficit Reduction Act concept, physicians still do not have the decision-making information they need since Congress has not yet taken final action.

Under differing proposals adopted by two separate committees the House would continue the fee freeze for another year on 'non-participating' physicians. A House Ways and Means Committee proposal would grant reimbursement increases of an unspecified amount to participating physicians *only,* and would continue the present freeze on 'non-participating' physicians for 12 more months. However, under the approach adopted by the Energy and Commerce Committee, new reimbursement tiers would be established. The prevailing charge would be increased at the FULL economic index rate (approximately 4%) for those physicians who:

—are currently 'participating' and who continue to do so beginning October 1, 1985; and
—are currently 'non-participating,' but who opt into the program on October 1, 1985.

The prevailing charge would be increased by *one-half* of the economic index rate (=approximately 2%) for those physicians who:

—are currently 'participating,' but who opt out of the program beginning October 1, 1985; and
—are currently 'non-participating' and continue as such after October 1, 1985, but are accepting assignment on 100% of their Medicare claims.

When Congress returned from the recess on September 4, the Senate Finance Committee was expected to consider the Medicare fee freeze and 'participating/non-participating' physician issues. Those and other budget matters likely will have to be resolved in a House-Senate conference. Because of the urgent time constraints on physician decision-making, the AMA plans to notify the federation through high-priority communciations just as soon as Congress acts. The State Medical Society also will keep its members closely informed regarding this issue and recommends that physicians take no definite contract action until the final proposal is passed.■

Medicare Participating Program Re-Cap
Below is a concise re-cap of the elements contained in the two proposals affecting the Medicare participating physician issue.

Energy and Commerce Committee Proposal

84-85 Status →	85-86 Status =	Will Mean
Participating	Participating	Full economic increase* in prevailing charges
Non-participating	Participating	Full economic increase* in prevailing charges
Participating	Non-participating	1/2 of a full economic increase** in prevailing charges
Non-participating	Non-participating and accept assignment on 100% of Medicare patients	1/2 of a full economic increase** in prevailing charges
Non-participating	Non-participating	Reimbursement and charge levels will continue to be frozen for 12 months

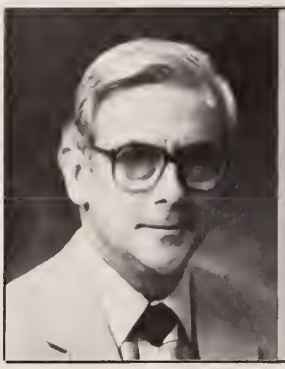
House Ways & Means Committee Proposal

84-85 Status →	85-86 Status =	Will Mean
Participating *or* Non-participating	Participating	Increase in reimbursement (not clear how much)
Participating *or* Non-participating	Non-participating	Freeze in reimbursement and charge levels will continue to be frozen for 12 months

*Full economic increase = approximately 4%
**1/2 economic increase = approximately 2%

Brown CMS plan wins acclaim

A return-to-work program of health cost containment started by the Brown County Medical Society with a local healthcare coalition is being promoted as a 'model' by the American Medical Association. It is featured in a 28-page report by the AMA on coalitions. Members may obtain a copy by calling the AMA 312/645-4716, Susan Kuntz.■



wispac

William L Treacy, MD; Chairman
WISPAC Board of Directors

AMPAC leader reports:

"Major upheaval in the health-care environment is challenging physicians to change the way in which we practice medicine. We in the medical community must speak up, become a part of that change, and guide the future course toward the best possible outcome for physicians and patients," American Medical Political Action Committee (AMPAC) Chairman Thomas R Berglund, MD, told the AMA House of Delegates.

In his report, Doctor Berglund said AMPAC offered the best vehicle for the medical community to affect changes in the way physicians practice medicine. Although physicians' financial support of AMPAC is vital for it to continue the work that has earned it a reputation as a respected leader and innovator in the political arena, this is not enough, he said.

"Every interest group with a special cause in Washington is raising money, particularly those with an agenda opposing physicians' interests. More importantly, those groups are mobilizing their people, encouraging their membership to become active in the legislative and political process. This upsurge in grassroots activity is good for democracy, good for America, and good for physicians if we jump into the parade and make it work to our advantage," Doctor Berglund said.

"Physicians and their spouses can start by becoming AMPAC members, but I urge you, in fact, implore you to take one step beyond AMPAC membership—become an active participant in the political process. The excuse 'I am too busy' can no longer be used because you can give as little or as much of your time as possible and still have a crucial effect."

Beyond making a financial donation, the possibilities are endless, he told the delegates. He offered several suggestions for physicians: To find a candidate who supports their views and offer their services as a health policy advisor, fund-raiser, or campaign volunteer; to participate at the local, state, or national level of party politics; or to establish regular contact with elected representatives to let them know their views on certain issues.

Physicians need not stick to one side of the political fence, nor all group together under one party banner. In fact, the more campaigns we participate in, the more certain we can be that our voices will be heard on all sides," Doctor Berglund said.

Doctor Berglund's comments at the June AMA meeting are true not only at the national level but also right here in Wisconsin. Physician participation in the process will help to effectively guide the course of change.

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John K Scott, MD, Madison
Charles Landis, MD, Milwaukee
Robert Purtell, MD, Milwaukee
Mrs Jeri Cushman, Racine
Mrs Ann Shea, DePere
Mrs Jackie Dungar, Appleton■

DISTRICT 1
Lois Riley
(414/271-4328)

County medical societies

Milwaukee
Waukesha
Ozaukee
Washington
Sheboygan
Kenosha
Racine
Walworth

DISTRICT 2
Lanny Hardy
(608/257-6781)

County medical societies

Columbia-Marquette
Adams
Green Lake-
Waushara
Lafayette
Richland
Jefferson
Green
Iowa
Grant
Rock
Dane
Dodge
Juneau
Sauk

DISTRICT 3
Deborah Bowen Wilke
(414/964-5046)

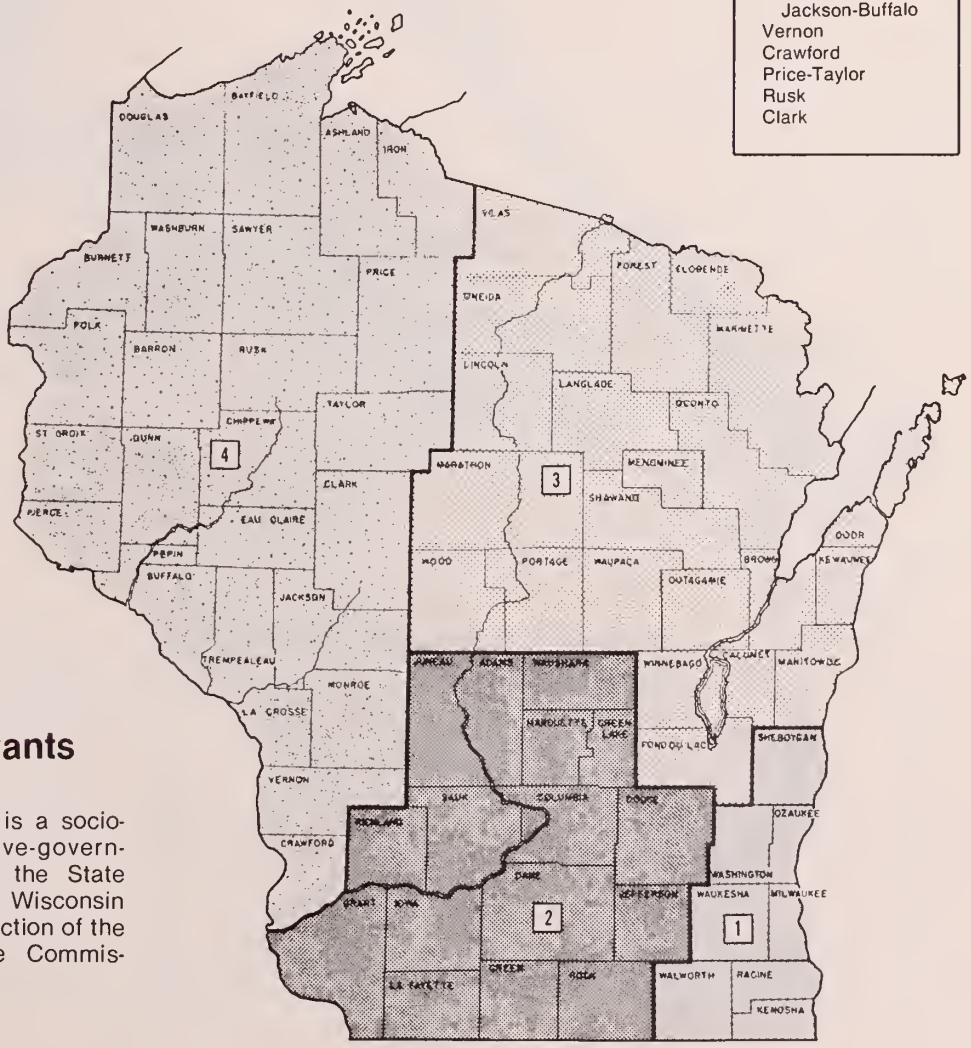
County medical societies

Oneida-Vilas
Lincoln
Marinette-Florence
Forest
Langlade
Shawano
Outagamie
Brown
Door-Kewaunee
Calumet
Oconto
Marathon
Wood
Portage
Waupaca
Winnebago
Fond du Lac
Manitowoc

DISTRICT 4

County medical societies

Ashland-Bayfield-
Iron
Douglas
Barron-Washburn-
Burnett
Sawyer
Polk
Pierce-St Croix
Chippewa
La Crosse
Monroe
Eau Claire-Dunn-
Pepin
Trempealeau-
Jackson-Buffalo
Vernon
Crawford
Price-Taylor
Rusk
Clark



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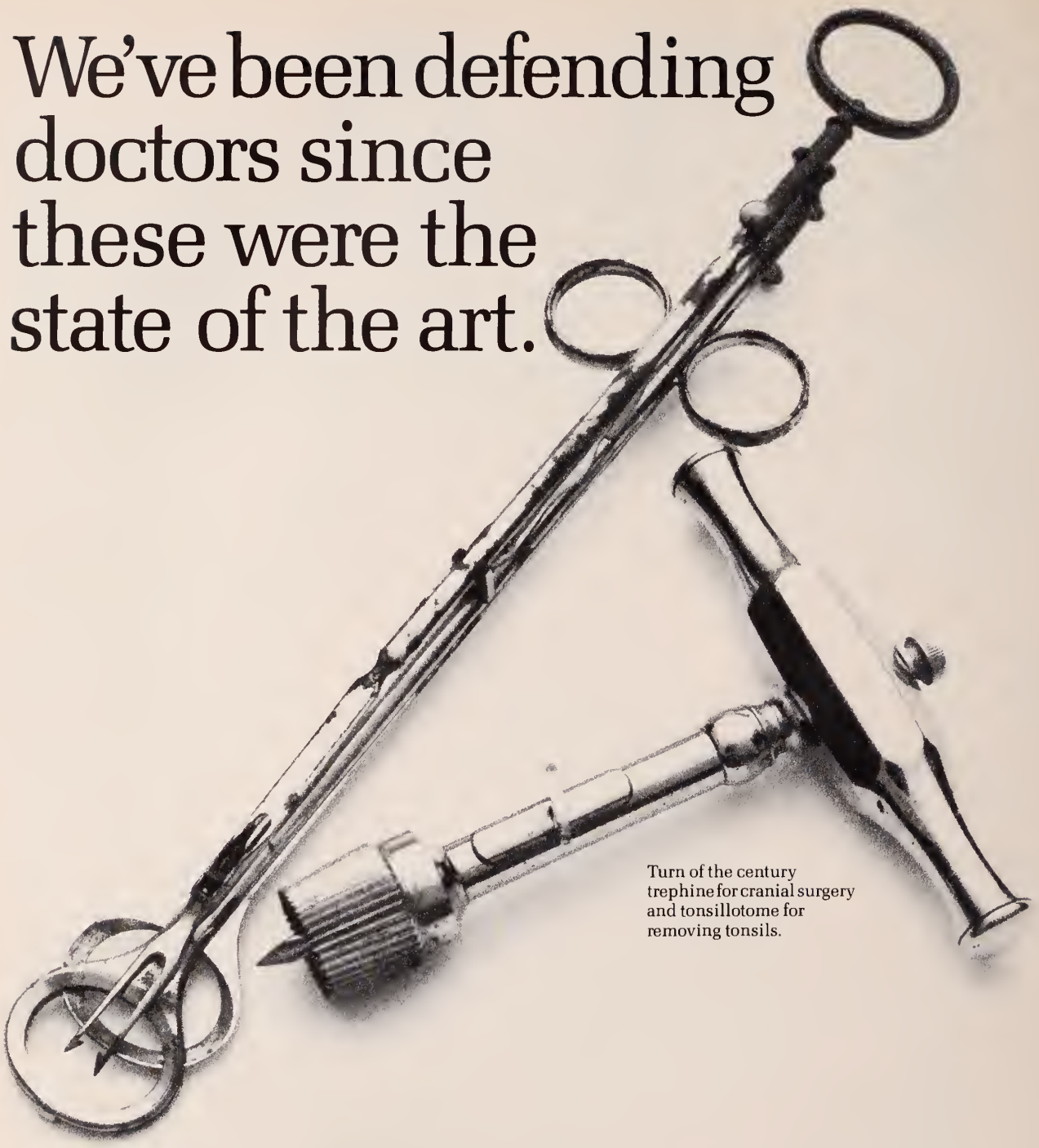

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Albert J Motzel Jr, MD,* Waukesha, has been elected vice-president of medical staff affairs for Waukesha Memorial Hospital. Doctor Motzel joined the medical staff of Waukesha Memorial Hospital in 1958. He was appointed director of medical education in 1971 and coordinator of medical staff affairs in 1979. Since 1958 he has served on the faculty of the Medical College of Wisconsin, where he is now an associate clinical professor of surgery. Doctor Motzel served as president of the State Medical Society (1980-81) and president of the Waukesha County Medical Society (1972-73).

P Michael Shattuck, MD, Berlin, recently joined the medical practice of William C Piotrowski, MD.* Doctor Shattuck graduated from the Indiana University Medical School and completed his residency from the Fox Valley Family Practice Residency Program.

Mark H Andrew, MD, Viroqua, recently joined the medical staff of the Vig-Gundersen Clinic in Viroqua. Doctor Andrew graduated from the University of Wisconsin Medical School, Madison, and completed an internship and residency at the Southwest Michigan Area Health Education Center, Kalamazoo, Mich.

Carol A Kotzan, MD, Madison, recently joined the Jackson Clinic and is the director of the Immediate Care Department. Doctor Kotzan is a graduate of the University of Michigan, Ann Arbor, and the Medical College of Ohio, Toledo. She served her internship at the Henry Ford Hospital, Detroit, and completed her residency at the University of Wisconsin Medical School, Madison.

Peter B Idsvoog, MD, Madison, has joined the Department of Internal Medicine at the Jackson Clinic. Doctor Idsvoog graduated from the University of Wisconsin Medical School, Madison, where he also completed his residency. Prior to joining the Jackson Clinic, Doctor Idsvoog served as an emergency room physician at St Claire Hospital in Monroe.

Joyce Brehm, MD,* Stoughton, has begun her medical practice with the Stoughton Dean Clinic. Doctor Brehm graduated from the University of Wisconsin Medical School, Madison, and completed her residency at the University of Nevada Affiliated Hospital. She formerly was associated with the Medical Center of Monroe.

James R Kravig, MD, St Croix Falls, has joined the medical staff of River Valley Medical Clinic. Doctor Kravig graduated from the University of Minnesota School of Medicine and completed his residency at Hennepin County Medical Center.

Joseph B Fuller, MD, Superior, recently became associated with the Superior Clinic, Ltd. Doctor Fuller graduated from the University of Iowa Medical School and served his residency at the University of Illinois College of Medicine affiliated program.

Robert K Gribble, MD, Marshfield, has become associated with the Department of Obstetrics and Gynecology at the Marshfield Clinic. Doctor Gribble graduated from the University of Wisconsin Medical School, Madison, where he also completed his residency at the University of Wisconsin Hospital and Clinics.

Jess R Nickols Jr, MD, Monroe, has begun his medical practice with The Monroe Clinic. Doctor Nickols served his internship at the Baylor University Medical Center, Dallas, TX, followed by residencies at the University of Arkansas and the University of Massachusetts Medical School in Worcester. He is a member of the American Academy of Neurology and will be associated with MDs Sig Q Jew* and R Arthur Gindin* in the Department of Neurology and Neurosurgery at the Clinic.

Kathleen Farah, MD, has become associated with the medical staff at Curtis Medical Clinic, Baldwin. A graduate from the University of Minnesota Medical School, Doctor Farah completed her residency in St Paul-Ramsey Medical Center in Minnesota. The Clinic is a division of Ramsey Clinic which is based in St Paul. She affiliated with the Baldwin Community Memorial Hospital.

Dana S Ziebel, MD, Monroe, recently became a member of the medical staff of The Monroe Clinic. Doctor Ziebel graduated from the State University of New York Upstate Medical Center in Syracuse and completed her residency at Rush-Presbyterian-St Luke's Medical Center in Chicago.

David Chang, MD, Marshfield, has joined the medical staff of the Marshfield Clinic. Doctor Chang graduated from the Korea University Medical School. He completed his residency at the Poly Clinic Medical Center, Harrisburg, PA, and the University of Medicine and Dentistry in Newark, NJ. He also completed a fellowship in pediatric anesthesiology at Buffalo Children's Hospital in New York.

Paul D Rasmussen, MD, Oconomowoc, recently joined the medical staff of the Wilkinson Clinic SC. Doctor Rasmussen graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency at the Medical College of Wisconsin in Milwaukee.

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Steven A Halsey, MD, Green Bay, has joined Family Practice Associates of Green Bay Ltd. He graduated from the Mayo Medical School, Rochester, MN, and completed his residency at Appleton in the Fox Valley Family Practice Residency Program.

Douglas MacLean, MD, Mondovi, recently joined the Mondovi Family Health Clinic. Doctor MacLean is a graduate of the University of Minnesota Medical School where he also completed his internship and residency.

Brian Harrison, MD, Mondovi, recently joined the Mondovi Family Health Clinic. Doctor Harrison graduated from the Mayo Medical School in Rochester, MN. He completed his residency at Appleton in the Fox Valley Family Practice Residency Program.

Kevin H Ruggles, MD, Marshfield, has joined the Department of Neurosciences at the Marshfield Clinic. Doctor Ruggles graduated from the University of North Dakota School of Medicine and served an internship at the Medical College of Wisconsin, Milwaukee. His residency was completed at the National Naval Medical Center, Bethesda, MD, and at the National Institutes of Health. He previously had practiced at the Naval Regional Medical Center in Oakland, CA.

Elson L So, MD, Marshfield, recently became associated with the Department of Neurosciences at the Marshfield Clinic. Doctor So graduated from the University of Santo Tomas, Manila, The Philippines, where he also served his internship. His residency was completed at the Bowman Gray School of Medicine, Winston-Salem, NC. Prior to joining the Clinic, Doctor So was an assistant professor at the medical College of Georgia, Augusta, and also was the director of the EEG Laboratory at the Veterans Administration Medical Center in Augusta.

Paul A Caviale, MD, Manitowoc, has joined the medical staff of Orthopaedic Associates of Manitowoc. Doctor Caviale is a graduate of the Medical College of Wisconsin, Milwaukee, and served his internship at St Francis Hospital, Wichita, KS. His residency was completed at St Francis Regional Medical Center in Wichita.

Jodelle L Bentley, MD, Monroe, has joined the Department of Obstetrics and Gynecology at The Monroe Clinic. She graduated from the University of Florida College of Medicine in Gainesville, and completed her internship and residency at the University of Texas Medical Center Hospital. Prior to coming to Monroe, Doctor Bentley was in private practice with the Southwest Medical Group in San Antonio, TX.

Joseph M Benforado, MD, Madison, has been elected vice president of the United States Pharmacopeial Convention for the term from 1985-1990. Doctor Benforado is professor of medicine at the University of Wisconsin in Madison. He is a graduate of the New York State College of Medicine at Syracuse and has taught and did research in pharmacology at Harvard, Oxford, England, and Buffalo. In his present position as physician-clinical pharmacologist, he teaches, sees patients at the University Health Service, and does consultation for alcohol and other drug problems at University Hospital and Clinics, Madison. He has been a USPC delegate since 1960 and currently has review responsibilities for the Credential Committee, Constitution and Bylaws Committee, and USP DI.

Robert K DeMott, MD, Ladysmith, has joined the medical staff of Marshfield Clinic-Ladysmith Center. Doctor DeMott graduated from the University of Wisconsin Medical School, Madison, and completed his residency at the University of Pittsburgh Health Center.

William James Wittman, MD,* Oconto Falls, recently became associated with Robert Artwich, MD.* Doctor Wittman graduated from the University of Minnesota Medical School and completed his internship at Sioux Valley Hospital and his residency at the Marshfield Clinic.

Sam Poser, MD, Columbus, has joined the Poser Clinic in Columbus. Doctor Poser graduated from the University of Wisconsin Medical School, Madison, and completed his residency at the University of Hawaii.

Doctor Spellman

Doctor Benforado

Robert J Spellman, MD,* New Berlin, has been promoted to medical director at the Northwestern Mutual Life Insurance Co in Milwaukee. Doctor Spellman was associate medical director before his promotion. Doctor Spellman graduated from Johns Hopkins Medical School, Baltimore, in 1973. He is a member of the teaching and examining faculty of the Board of Insurance Medicine and also serves as a consultant to the Risk Factor Committee of the Wisconsin Heart Association.

Richard A Cooper, MD, director of the University of Pennsylvania Cancer Center, has been named dean and academic vice president of the Medical College of Wisconsin, Milwaukee. Doctor Cooper, a native of Milwaukee, returns after an absence of almost 30 years. He took office July 1, 1985. He currently serves on the Advisory Group of the President's Cancer Panel/ACS Survey of Construction Requirements of the Nation's Cancer Research Facilities. He also serves on the Cancer Center Support Review Committee of the National Institutes of Health; and on the Food and Drug Administration, Expert for National Center for Drugs and Biologicals. Doctor Cooper received his BS degree from the University of Wisconsin and is a graduate of Washington University School of Medicine and took his postgraduate training at Boston City Hospital and at the National Institutes of Health. He has been director of the University of Pennsylvania Cancer Center since 1977 and as associate director since 1973.

Richard G Roberts, MD,* Darlington, recently was appointed to the Committee on Professional Liability of the American Academy of Family Physicians. The Committee was created by the Board of Directors for the purpose of reviewing the medical liability situation as it relates to the family physician.

Larry McFarlane, MD, recently became associated with the Riverview Clinic in Chippewa Falls. Doctor McFarlane graduated from the University of Wisconsin Medical School, Madison, and completed his pediatric residency at the Marshfield Clinic/St Joseph's Hospital in Marshfield. He most recently was in private practice in Dickinson, N Dak.

Fred Ansfield, MD,* Clam Lake, Emeritus Professor of Human Oncology at the University of Wisconsin, Madison, recently received the "1985 Emeritus Faculty Award" from the Wisconsin Medical Alumni Association for his pioneering work in chemotherapy. Doctor Ansfield joined the University of Wisconsin Medical School in 1957. He is a 1933 graduate of the University of Wisconsin Medical School and served his internship and residency at the Milwaukee County Hospital. He is a veteran, serving in the US Army Medical Corps during World War II, and the recipient of the Bronze Star, the Purple Heart, and the Silver Star.■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

JUNE 1985

*Bauer, William, Milwaukee
*Bormann, Joel A, Cumberland
*Brazy, Robert R, West Allis
*Bujard, Robert S, Milwaukee
Coates, John T, Schofield
Cooper, Ronald J, Waukesha
*Dedmon, Robert E, Neenah
*El-Wakil, Mamdouh E, Superior
*Erickson, Scott S, Marshfield
*Fletcher, Fred W, Eagle River
*Freund, Bernard W, Kenosha
Gehring, Charles J, Sheboygan
Halsey, Steven A, Green Bay
*Handler, Bruce, La Crosse
Harrison, Brian D, Appleton
Johnson, Steven R, Milwaukee
Johnston, Hugh F, Madison
Korte, Stephen A, La Crosse
*Kunkel, James A, Marshfield
*Larson, Richard D, Marshfield
Maney, James P, Milwaukee
Mc Laughlin, Janice M, Shorewood
Moore, Jordan A, Ashland
Neilley, Gregory S, Madison
*Praxel, Theodore A, Marshfield
*Rahr, Henry C, Green Bay
*Ramos, Teodoro M, Ripon
*Ries, Peter M, Marshfield
*Saladar, Rafael S, Beloit
*Schroeter, Neal J, Marshfield
*Shehab, Naglaa, Marshfield
Sperry, Leonard T, Milwaukee
Stone, Shirley J, Milwaukee
*Stueland, Dean T, Marshfield
*Sutton, Thomas M, Marshfield
*Tang, Thomas Tze-Tung, Milwaukee
Tempelis, Laurence, Wauwatosa
Thompson, Kenneth M, Milwaukee
Uber, Christine L, Wisconsin Rapids
*Zondlo, Joseph G, Green Bay

JULY 1985

*Alston, James A, Waukesha
*Brousseau, Edward R, Eau Claire
Chang, Chen-Kang, Madison
Factor, Robert M, Madison
*Falk, Victor S, Edgerton
*Galarnyk, Ihor A, Plain
*Gohdes, Paul N, Neenah
Hahn, Michael F, Janesville
*Halloran, William R, Milwaukee
*Holt, James J, Marshfield
*Josephson, Morton, Wauwatosa
*Kangayappan, Sivakami, Manitowoc
*Kim, Byung H, Racine
*Laing, Robert E, Racine
Miller, Lawrence H, Waupun
*Mills, E Grady, Marshfield
*Pederson, John F, La Crosse
Reganti, Venkata R, Neillsville
*Shapiro, Robert B, Madison
*Sovine, David L, Glendale
Thalberg, Steven A, Milwaukee
*Walbrun, Fred H, Pulaski
Waldron, John Becker, Rice Lake
*Walters-Jones, Beth, Reedsburg
*Zeldenrust, John C, Two Rivers■

*Members of the State Medical Society of Wisconsin

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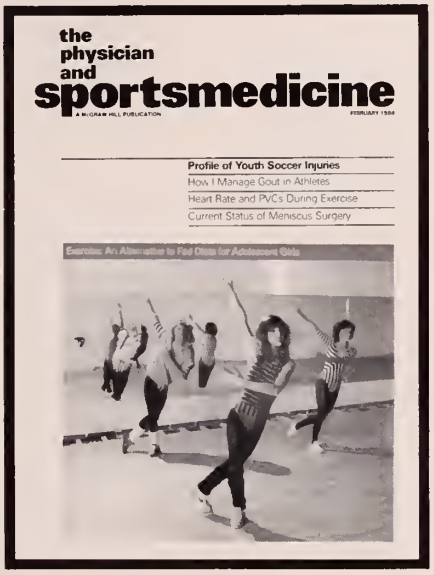

Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.

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Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1986 are $455 for SMS, $375 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin
DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1986 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455	$375	Normal County Dues
Resident	45.50	45	Varies
Military Service	–0–	250 or 45	–0–
Associate	–0–	–0–	–0–
Life	–0–	–0–*	–0–
Honorary	–0–	–0–*	–0–
Retired	–0–	–0–*	–0–
Part-time Practice	227.50	375*	Normal County Dues
Over Age 70	227.50	375*	Normal County Dues
Scientific Fellow	–0–	–0–	
Emeritus	–0–	–0–*	
Candidate—			
Freshman Year Medical Student	–0–	20	Varies
Sophomore and Succeeding Medical Student Years	10	20	Varies
Postgraduate—One	10	45	Varies

* Physicians in the following categories may be eligible for exemption or reduction from paying AMA dues: (1) Financial hardship and/or disability, (2) Over 70 years of age or older *and* fully retired

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

15 MONTHS FOR THE PRICE OF 12!

Membership policy allows physicians to join their county and state societies and the AMA, or just their county and state societies. Physicians are encouraged to join organized medicine now. Regular membership dues for 1986 are: $455 for SMS, $375 for AMA, and county society dues vary. However, physicians who join now will not pay any dues for the balance of 1985. That's 15 months for the price of 12! Membership applications may be obtained by contacting the secretary of your county medical society or by calling the Membership and Communications Division at the State Medical Society offices in Madison at 608/257-6781 or toll free: 800/362-9080.■

PHYSICIANS EXCHANGE

Internist or psychiatrist who is Board certified or eligible with training in internal medicine *and* psychiatry is desired to direct a medical services department in a 150-bed psychiatric hospital and coordinate consultation liaison services with community health care facilities and physicians. The hospital is an agency of the Michigan Department of Mental Health and is located in Traverse City, Michigan, a diverse and growing community on Lake Michigan serving as a regional hub for northwestern lower Michigan. Traverse City Regional Psychiatric Hospital is an equal opportunity employer offering regular hours, excellent benefits and competitive salary. A position for a qualified physician in internal medicine or psychiatry, independent from other specialty training may also be available. If interested, please contact G Robert Miller, MD, Traverse City Regional Psychiatric Hospital, Box C, Traverse City, MI 49684. 9/85

OB/GYN: BC/BE to join three OB-GYNs in 31-physician multispecialty group. Beautiful lakefront community of 90,000 located between Milwaukee and Chicago offers a wealth of cultural, educational, and recreational opportunities. Well-equipped clinic and two local hospitals; salary guarantee with incentive bonus; excellent fringe benefits and early partnership. Send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

General and surgical solo practice for sale. Gross in excess of $300,000. Growing desirable midwestern university city with population 25,000. One very well-equipped hospital in county of 60,000 a few blocks away. Owner will remain to introduce. Contact Dept 563 in care of the Journal. 9tfn/85

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Ophthalmologist, subspecialty pediatrics or glaucoma helpful but not required, Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Must be willing to do general ophthalmology. Immediate drawing area 100,000 with unopposed subspecialty referral area much higher. Located on Lake Michigan with excellent recreational activities. Optometric support available. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Pediatrics/Neonatology: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits, and early ownership. Neonatology skills needed for Level II Nursery. Please send curriculum vitae to R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

General Internist. Marshfield Clinic, one of the nation's largest multispecialty private groups, is seeking several Board certified/Board eligible General Internal Medicine specialists to join its expanding 16-member section. Internal Medicine Residency Program, University affiliation, Research Foundation, and large regional referral base contributes to a very stimulating environment. Unique big city medicine opportunity in a family-oriented rural setting. Please send curriculum vitae to: John P Folz, Assistant Director, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or call collect at 715/387-5181. 9-11/85

Internist with or without subspecialty interest. Board Certified or eligible, to join six other internists in a well-established, 23-man expanding multispecialty group in prosperous lakeside southeastern Wisconsin city of 36,000. The Internal Medicine Department currently has subspecialties in cardiology, pulmonary medicine, and medical oncology. Liberal fringe benefits. Initial salary plus percentage as associate. Full status in service corporation, with incentive-oriented formula after first year. Contact J F Kuglitsch, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935; ph 414/923-7420 collect. 5tfn/85

Appleton, Wisconsin seeking physician for weekend coverage at family practice clinic affiliated with local hospital. Flexible hours and attractive compensation. Submit resume to Emergency Consultants, Inc, 2240 South Airport Rd, Traverse City, MI 49684; 1-800/253-1795 or in Michigan 1-800/632-3496. p9/85

Primary care physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to: Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. 9-12/85

We are seeking three (3) Board certified/eligible family practice physicians for a new Ambulatory Care Center in the Milwaukee area; attractive work hours and financial package. Please send CV or call: Ms Debbie Carsky, Director of Recruitment, MESA (Medical Emergency Service Associates), 15 S McHenry Rd, Buffalo Grove, IL 60089; 312/459-7304. 9/85

Family Practice: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary gaurantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Ophthalmologist. Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Immediate drawing area 100,000. Located on Lake Michigan with excellent recreational activities. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Family Practice opportunity to join a four-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1-1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, Wis 53916; ph 414/887-7101. 5tfn/85

PHYSICIANS EXCHANGE

continued

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 4-9/85

Internist. BC/BE to join Internal Medicine Department of multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St. Green Bay, WI 53403; ph 414/494-5611 p6-9/85

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

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Contact: Ms Debbie Carsky, Director of Recruitment, 312/459-7304 (collect) or write to 15 South McHenry Road, Buffalo Grove, IL 60090. 9/85

Urgent care physician and internist. Opportunities available as clinic services expand. This 35-member multispecialty group, including 13 internists, is housed in a modern facility next to the 240-bed Mercy Hospital and has a drawing area of 100,000. Send CV with inquiry: Ernest C Deeds, MD, Box 551, Janesville, WI 53547. p8, 9/85

Wisconsin: Pediatrician with subspecialty interest to join multispecialty clinic that includes general pediatricians, pediatric hematologist, oncologist and neonatologist in city of 150,000. Send CV to Dept 561 in care of the Journal. 8tfn/85

Emergency physicians wanted. Part-time positions available in a moderate volume emergency room in Beloit, Wis. Must have an active interest in community relations. ACLS required. ATLS desirable. If interested, contact John Maher, MD, Director, Emergency Department, Beloit Memorial Hospital, 1969 W Hart Rd, Beloit, WI 53511. 8-9/85

Family practice physician, internist and OB/GYN physicians needed to join a multispecialty clinic in NE Wisconsin. Excellent starting salary, full benefits, partnership one year, HMO affiliated. Contact Stephen C Caselton, MD, 2152 Riverside Ave, Marinette, Wis 54143; ph 715/732-2211. p8-10/85

Versatile Surgeon wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E Johnson, Ely Medical Center, Ltd, 224 East Chapman Street, Ely, Mn 55731; ph 218/365-3151. 6tfn/85

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone 608/263-4095 7/85-6/86

Cardiology position desired in the metropolitan Milwaukee area. University trained in both invasive and noninvasive cardiology. Heavy emphasis throughout training in all aspects of critical care. Board certified in internal medicine. Will complete fellowship and be available in August or September of 1986. Interested parties should contact Dept 560 in care of the Journal. 8-10/85

Internist-Infectious Disease Physician. The Racine Medical Clinic, a progressive cluster corporation of 32 physicians, is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 6tfn/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

This space available
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(1½ column inches)

PHYSICIANS EXCHANGE

continued

West Bend, Wisconsin, General Clinic, a (18) physician multispecialty group, is seeking physicians in the specialties of Internal Medicine, Family Practice, OB/GYN, and Pediatrics. First-year salary guaranteed. Corporate membership possible after one year. Excellent fringe benefits. Located in scenic, recreational area with close proximity to Milwaukee. Please contact Hans W Schmelzling, Administrator, General Clinic, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 6tfn/85

Otolaryngologist. BC/BE to join busy ENT Department within 23-member multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611. 6-9/85

Obstetrician/Gynecologist, Board eligible/certified, for Green Bay metropolitan area. Large multispecialty clinic with excellent salary and benefits. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 53403; ph 414/494-5611 p6-9/85

OB/GYN, and internist to join seven-doctor family practice clinic in Cloquet, Minnesota, a community of 14,000 (30,000) service area, located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped, 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally our community is noted for its excellent school system. First-year salary guarantee; paid malpractice, health, and disability insurance; vacation and study time. Contact John Turonie, Administrator, Raiter Clinic Ltd, 417 Skyline Blvd, Cloquet, Minnesota 55720. Telephone 218/879-1271. 7-9/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

Attractive opportunity for a Board certified/eligible family physician to establish a new community practice. The family practitioner will be eligible for full-hospital privileges at Beloit Memorial Hospital, a medium-sized acute care facility. This opportunity offers a guaranteed financial and start-up package. Inquiries or CV should be directed to Gregory K Britton, Administrative Director, Beloit Memorial Hospital, 1969 West Hart Road, Beloit, Wisconsin 53511; ph 608/364-5104. p6-8;g9/85

Excellent opportunity for a Board certified or eligible internist to practice in conjunction with an 8-member Internal Medicine Department of a 26-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 6tfn/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

SEPTEMBER 27-29, 1985: Wisconsin Psychiatric Association, Wisconsin Center, Madison. g9/85

OCTOBER 4-5, 1985: *Wisconsin Association Parenteral Enteral Nutrition Third Annual Symposium: The State-of-the-Art in Nutritional Support* 1985. Marriott Hotel, Brookfield, WI. Outstanding guest speaker panel. Joni Newborn 414-289-8306 or Patricia Brosier 608-364-5011. p8/85; g9/85

OCTOBER 5-6, 1985: Wisconsin Allergy Society, Hyatt, Milwaukee. g9/85

OCTOBER 10-11, 1985: Fall Symposium of Wisconsin Chapter: American College of Emergency physicians & Emergency Department Nurses Association. The Abbey, Fontana. g7-9/85

OCTOBER 10-11, 1985: *Update in Allergy and Clinical Immunology II.* The Inn-Tower Hotel, Madison. Sponsored by Department of Continuing Medical Education and Department of Medicine, School of Medicine, University of Wisconsin-Madison. AMA Category I, University of Wisconsin CEUs. Family Practice credit has been applied for. Approximately 11 hours. Info: Ann Bailey, Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2854. 7-9/85

OCTOBER 18, 1985: *Understanding and Caring for the Person with Dementia (including Alzheimer's Disease).* Ross Levine, MD, Miriam Oliensis-Torres, MSW, faculty. Holiday Inn, Fond du Lac, WI. Approved for 5 hours of AMA/PRA Category I credit. Fee: $30. Info: Training Department, Mendota Mental Health Institute, 301 Troy Dr, Madison, WI 53704; ph 608/244-2411. 9/85

OCTOBER 25-26, 1985: *1985 Conference on Back Pain Rehabilitation,* Appleton, Wisconsin. Sponsored by Theda Clark Regional Medical Center, Neenah; and Continuing Medical Education, School of Medicine, University of Wisconsin-Madison. AMA Category I, and Continuing Education Hours—both approximately 11 hours. Contact Sarah Aslakson, Continuing Medical Education, 610 Walnut St, 465B WARF Bldg, Madison, WI 53705; ph 608/263-2856. 9/85

OCTOBER 26, 1985: Wisconsin Dermatological Society, Froederdt Memorial Lutheran Hospital, Milwaukee. g6-9/85

NOVEMBER 1-2, 1985: *Seminars in Pediatrics.* The University of Wisconsin Clinical Science Center, Madison. Sponsored by the Departments of Pediatrics and Continuing Medical Education, School of Medicine, University of Wis-

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

consin-Madison. AMA Category I, AAFP Prescribed, AOA Category 2-D, and University of Wisconsin CEUs—all approximately 11 hours. Contact: Sarah Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 9/85

NOVEMBER 8, 1985: *Recognizing and Treating Anxiety, Fear, and Phobias in Children.* Thomas Kratochwill, PhD, faculty. Conference Center, Mendota Mental Health Institute, Madison, WI. Approved for 6 hours of AMA/PRA Category I credit. Fee: $30. Info: Training Department, MMHI, 301 Troy Dr, Madison, WI 53704; ph 608/244-2411. 9/85

NOVEMBER 15-16, 1985: *Treating Depression and Manic-Depression Clinical Update—1985,* Sheraton Convention Center, Madison. Sponsored by Center for Affective Disorders and Lithium Information Center, University of Wisconsin Department of Psychiatry, and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA Category I—10 hours; University of Wisconsin Continuing Education Unit—1.0. Fee: $175 includes one lunch and refreshment breaks. Info: Ann R Bailey, CME, 454 WARF Bldg, Madison, WI 53705; ph 608/263-2854. 9/85

NOVEMBER 16, 1985: Wisconsin Society of Pathologists, American Club, Kohler. g9-10/85

NOVEMBER 18-21, 1985 (Louisiana): *A Primary Care Update,* the 70th Scientific Assembly of Interstate Postgraduate Medical Association. Accredited by ACCME and eligible for 24 hours of Category 1 and 4 hours of Category 5 credit of the AMA/PRA. Acceptable for 24 prescribed hours credit by American Academy of Family Physicians and 24 hours by the College of Family Physicians of Canada. Info: IPMANA, PO Box 1109, Madison, WI 53701 g9-10/85

NOVEMBER 21-23, 1985: *Update in Infectious Diseases 1985.* University of Wisconsin Clinical Science Center, Madison. Sponsored by Section of Infectious Disease, Department of Medicine, and Continuing Medical Education, School of Medicine, University of Wisconsin, in cooperation with the University of Wisconsin Hospital and Clinics. AMA Category I, University of Wisconsin CEUs—both 19 hours; AAFP credit pending. Contact: Sarah Aslakson, Continuing Medical Education, 610 Walnut St, 465B WARF Bldg, Madison, Wisconsin 53705; ph 608/263-2856. 9/85

JANUARY 25—FEBRUARY 1, 1986: *Sports Medicine Cruise Seminar,* SS Constitution, Hawaiian Islands. Sponsored by University of Wisconsin School of Medicine, Continuing Medical Education. AMA Category I credit 16 hours, Family Practice credit pending, and 16 hours University of Wisconsin CEUs. Contact: Ann Bailey, Department of Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison WI 53705; ph 608/263-2854. 7-9/85

OTHERS

OCTOBER 17-18, 1985 (Minnesota): *Toxic Chemicals in the Workplace: Health, Legal, and Regulatory Issues,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

OCTOBER 25, 1985 (Minnesota): *Promoting Healthy Lifestyles For Pregnant Women,* Earle Brown Continuing Education Center, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-9/85

ADVANCES AND CONTROVERSIES IN CARDIOLOGY—1985

1985 AHA of Wisconsin Annual Meeting

Friday, October 25, 1985
Hyatt Regency Hotel, Milwaukee

8:30 am - 3:30 pm

Special Presentations by Top Experts on:

- Predictors of Outcome in Patients with Coronary Disease
- Stress Test vs Radionucleide Study vs Coronary Angiography
- TPA in Acute Myocardial Infarction
- Magnetic Resonance in Cardiac Diagnosis

CEU and CME Credits

To register or for additional information contact: American Heart Association of Wisconsin, 795 North Van Buren St, Milwaukee, Wisconsin 53202; ph 414/271-9999 or 800/242-9236. 9/85

BIOFEEDBACK SOCIETY OF WISCONSIN

1985 Annual Conference

La Crosse, November 8-10, 1985

Topics include: *Optimizing Transfer of Self-Regulation Training;* and *Brain and Peripheral Laterlization;* by Charles Stroebel, MD, PhD-past president, Biofeedback Society of America.

Biofeedback Treatment in Children and Adolescents by Elizabeth Stroebel, MS, MEd—Hartford, Conn.

Issues of Patient Compliance in Biofeedback Practice by Mark Schwartz, PhD—Mayo Clinic.

For more information, contact University Counseling Center, UW-Stout, Menomonie, WI 54751; ph 715/232-2468. p9/85

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1986-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel.

1986—April 17-19
1987—March 26-28
1988—April 28-30
1989—April 13-15
1990—April 26-28
1991—April 18-20
1992—April 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

NOVEMBER 14-16, 1985 (Minnesota): *Clinical Strategies In Primary Care Medicine,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-10/85

DECEMBER 4-6, 1985: (Illinois): *Neurology for the Non-Neurologist,* The Westin Hotel, Chicago. Contact: University Office of Continuing Education, Rush University, 600 S Paulina, Chicago, IL 60612; ph 312/942-7095. p9-11/85

DECEMBER 5-7, 1985 (Minnesota): *Coronary Heart Disease: A Comprehensive Review of Principles and Practice,* Sheraton Midway Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-11/85

DECEMBER 27-30, 1985 (Florida): *Third International Symposium on Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias.* Wyndham Hotel, Orlando, FL. Sponsored by University of Wisconsin, Continuing Medical Education; Mount Sinai Medical Center, Milwaukee, Wisconsin; American Heart Association (Central Florida and Wisconsin Affiliates); Florida Heart Institute, Orlando, Florida; and Continuing Education and Research Foundation, Elm Grove, Wisconsin. AMA Category I, AAFP Elective, AOA Category 2-D, and University of Wisconsin CEUs—all 19 hours. Contact: Sarah Aslakson, University of Wisconsin, Continuing Medical Education, Room 465B WARF Bldg, 610 Walnut St, Madison, WI 53705; ph 608/263-2856. 9/85

FEBRUARY 11-16, 1986 (Mexico): *15th Annual Pediatric Postgraduate Course: Pediatric Update 1986,* at Camino Real, Cancun, Mexico. Sponsored by: Department of Pediatrics of the Schneider Children's Hospital, Long Island Jewish Medical Center. Approved 21 credit hours in Category 1 ACCME; AMA/PRA and approval pending AAFP. Info: Ann J Boehme, CME, Long Island Jewish Medical Center, New Hyde Park, NY 11042; ph 718/470-8650. 9/85

FEBRUARY 13-14, 1986 (Michigan): *Tenth Annual Winter Pediatric Conference* at Powderhorn Ski Area, Ironwood, Michigan. Guest speaker is James A Stockman, III, MD. Info: Marshfield Medical Education Department or H James Nickerson, MD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wisconsin 54449. 9-12/85; 1-86

WEEKLY SEMINARS

Most major ski areas, Club Med, Disney World, Cruising aboard Sailboats in the Virgin Islands or a Mississippi Paddlewheeler. Topic: ***Medical-legal issues.***

Current Concept Seminars, Inc (since 1980). 3301 Johnson St, Hollywood, FL 33021; ph 800/428-6069. $175. p9-12/85; 1-2/86

National Conference on Health Policy and Quality of Care for Older Americans

Tuesday and Wednesday November 12-13, 1985

Alexandria, Virginia
Radisson Mark Plaza Hotel

Cosponsors:
American Medical Association
American Association of Retired Persons
American Hospital Association
American Nurses' Association
Conference Headquarters:
(312) 645-4727

Because of the paramount importance of the critical issues involved in assuring high quality healthcare for older Americans, the cosponsors are joining forces to heighten a sense of commonality and interdisciplinary understanding of the problems that confront the medical community. Emphasis will be placed on the vital areas of financing, delivery, and assurance of high quality healthcare.

Who should attend: All concerned with healthcare and aging policy including Congressional Members, Government and Agency Staff, Healthcare Professionals, Institutional Administrators and Staff, Advocates for Older Americans.

Registration fee: $175 includes admission to all sessions, two lunches, and a reception.

Reservations: Call toll-free 1-800-621-8335.

James H Sammons, MD, Executive Vice President of the American Medical Association, urges physicians to attend this *first* National Conference of its kind.

AMA

DECEMBER 8–11, 1985: Interim AMA House of Delegates, Washington, DC.

JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

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PBBS Equipment 9
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Motrin® ■

MALPRACTICE CONFERENCE TAPES AVAILABLE. Audiocassette tapes are now available from the May 10-11 medical malpractice conference sponsored by the State Medical Society. The conference featured national authorities as well as local experts who addressed medical liability issues from a variety of perspectives. Speakers included: Ira A Cohen, JD, New York City; Richard J Phelan, JD, Chicago; Richard G Roberts, MD, JD, Darlington; Sara C Charles, MD, Chicago; and Elvoy Raines, JD, Boston. Practical suggestions offered included minimizing the risk of suit, development of a solid defense in the event a claim arises, and the psychological impact of malpractice suits on physicians. The tapes are available on a loan basis, free of charge from SMS Offices in Madison. Contact Deb Powers in the Physicians Alliance Division.■

JCAH PUBLISHES THE HOSPICE PROJECT REPORT. The Joint Commission on Accreditation of Hospitals (JCAH) has announced publication of the *Hospice Project Report.* The Hospice Project began in March 1981 when the WK Kellogg Foundation of Battle Creek, Michigan awarded a grant to JCAH to study the characteristics of hospice care in the United States and to develop standards for hospice based on study findings. The two and a half year study focused on determining the number of hospices, the organizational structures and services of hospices, and the characteristics of the personnel involved in providing hospice care. More than 200 hospices nationwide participated in the study, and the findings provide a complete profile of hospices in the United States. To order your copy of the *Hospice Project Report,* send $25 per copy to: Cashier, JCAH, 875 North Michigan Ave, Chicago, IL 60611.■

SMS TESTIFIES ON PITUITARY GLAND REMOVAL LEGISLATION. At a legislative hearing July 30 the State Medical Society offered testimony in support of SB 219, which would allow removal of the pituitary gland in the course of an autopsy. The pituitary gland would then be sent to the National Hormone and Pituitary Program which extracts human growth hormone and distributes the hormone to physicians treating children needing it. In its written testimony SMS indicated that SB 219 would increase the supply of a hormone essential in treating hypopituitarism, yet at the same time it would provide appropriate safeguards surrounding the process of organ removal including: 1) the transfer of pituitary gland may only be to the National Institutes of Health, and 2) removal is authorized only when an autopsy is ordered by the coroner, medical examiner, or district attorney under s. 979.02, or when an autopsy is otherwise performed by a medical examiner. Chesley P Erwin, MD, medical examiner for Milwaukee County and a past president of the State Medical Society, has appeared on the Society's behalf at previous hearings on this legislation. Members wishing more information on this legislation may contact Terry Hottenroth of the Physicians Alliance Division at SMS Offices in Madison: 608-257-6781 or 1-800-362-9080.■

MEDICARE PARTICIPATING PHYSICIAN ISSUE UPDATE. With time running out on the October 1 deadline for physicians to make their Medicare determinations on whether to be "participating" or "non-participating" under the second year of the Deficit Reduction Act concept, physicians still do not have the decision-making information they need since Congress has not yet taken final action. State Medical Society members are urged by President Scott to read the article appearing elsewhere in this issue explaining the two proposals affecting the Medicare participating physician issue.■

WISPAC NEEDS YOUR SUPPORT. With the Legislature back in session from September 24 through October 18, WISPAC is working throughout the state to increase physician involvement in the political process and strengthen Medicine's position in the legislative forum. Much has been accomplished, but the stage is set to accomplish even more. This year WISPAC set membership goals for each county medical society (40% of county medical society membership). The following counties already have reached that level: Calumet, Clark, Fond du Lac, Grant, Green Lake/Waushara, Juneau, Langlade, Manitowoc, Monroe, Oneida/Vilas, Sauk, Shawano, and Washington. WISPAC members particularly are urged to persuade their colleagues to join. Further details appear in the WISPAC column elsewhere in this issue.■

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

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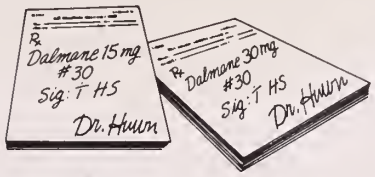

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, back and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

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WISCONSIN MEDICAL JOURNAL

Official Publication of the State Medical Society of Wisconsin

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Replantation for ring avulsion injuries

Authors Rao and Feins present four cases of ring avulsion injuries, which they acknowledge are difficult to treat. They show the results of such injuries and recommend that replantation be carried out whenever feasible. Also included is a diagram showing the method for preparation and preservation for transplantation with a note of warning that early, successful surgery depends on rapid transport. (See page 15)

OCTOBER 1985

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CONTENTS

October 1985

SPECIAL FEATURES

President's Page

5 RX for a busy physician
John K Scott, MD
Madison

Editorials

6 Saving more money in MoTown
Victor S Falk, MD
Edgerton

Irradiated foods
Victor S Falk, MD
Edgerton

Letters

10 An overview of the Medical Examining Board
Barbara Nichols, Secretary
Department of Regulation and Licensing
State of Wisconsin
Madison

Socioeconomics

44 Hearing held on PT practice without referral

47 SMS physicians testify for additional mental commitment standard

47 Bill waiving interest on overdue insurance claims rejected

News you can use

58 Changes made in unprofessional conduct definition

President Reagan's tax reform plan . . .

Future participation rates . . .

SCIENTIFIC MEDICINE

15 Replantation for ring avulsion injuries
Venkat K Rao, MD
Robert S Feins, MD
Madison

18 Lowering blood cholesterol to prevent heart disease
NIH Consensus Development Conference

19 ABSTRACT: Microscopically controlled surgery for periorbital melanoma: fixed-tissue and fresh-tissue techniques
Frederic E Mohs, MD
Madison

20 Old versus new antiparkinsonian agents?
Norman C Reynolds Jr, MD
Milwaukee

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Vol. 84 No 10

CONTENTS

22 Tuberculous otomastoiditis
Bruce H Campbell, MD
Thomas B Chatton, MD
Michael J Chusid, MD
Russell S Yale, MD
Milwaukee

24 Reflex sympathetic dystrophy snydrome: Importance of early diagnosis and appropriate management
Sridhar V Vasudevan, MD
Bruce Myers
Milwaukee

28 ABSTRACT: Microscopically controlled surgery in the treatment of carcinoma of the penis
Frederic E Mohs, MD
Stephen N Snow, MD
Edward M Messing, MD
Michael E Kuglitsch, MD
Madison

ORGANIZATIONAL

30 SMS hosts Soviet physicians at reception

31 Membership facts

32 Membership Directory—Update

45 Physicians Alliance districts and field consultants

48 OBITUARIES
Charles Francis Foley, MD
Sparta
Lucy A Vernetti, MD
Phoenix, Arizona (Hurley)
Francis E Gehin, MD
Stevens Point
Raymond J Murphy, MD
Green Bay
Lester E Haushalter, MD
Brookfield
Ruth E Church, MD
Whitewater (Waukesha)

DEPARTMENTS

49 PHYSICIAN BRIEFS

53 MEDICAL YELLOW PAGES
Physicians exchange
Medical facilities
Miscellaneous
Medical Meetings—Continuing Medical Education
Advertisers■

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 5700 member physicians in Wisconsin, comprising 55 county medical societies and 27 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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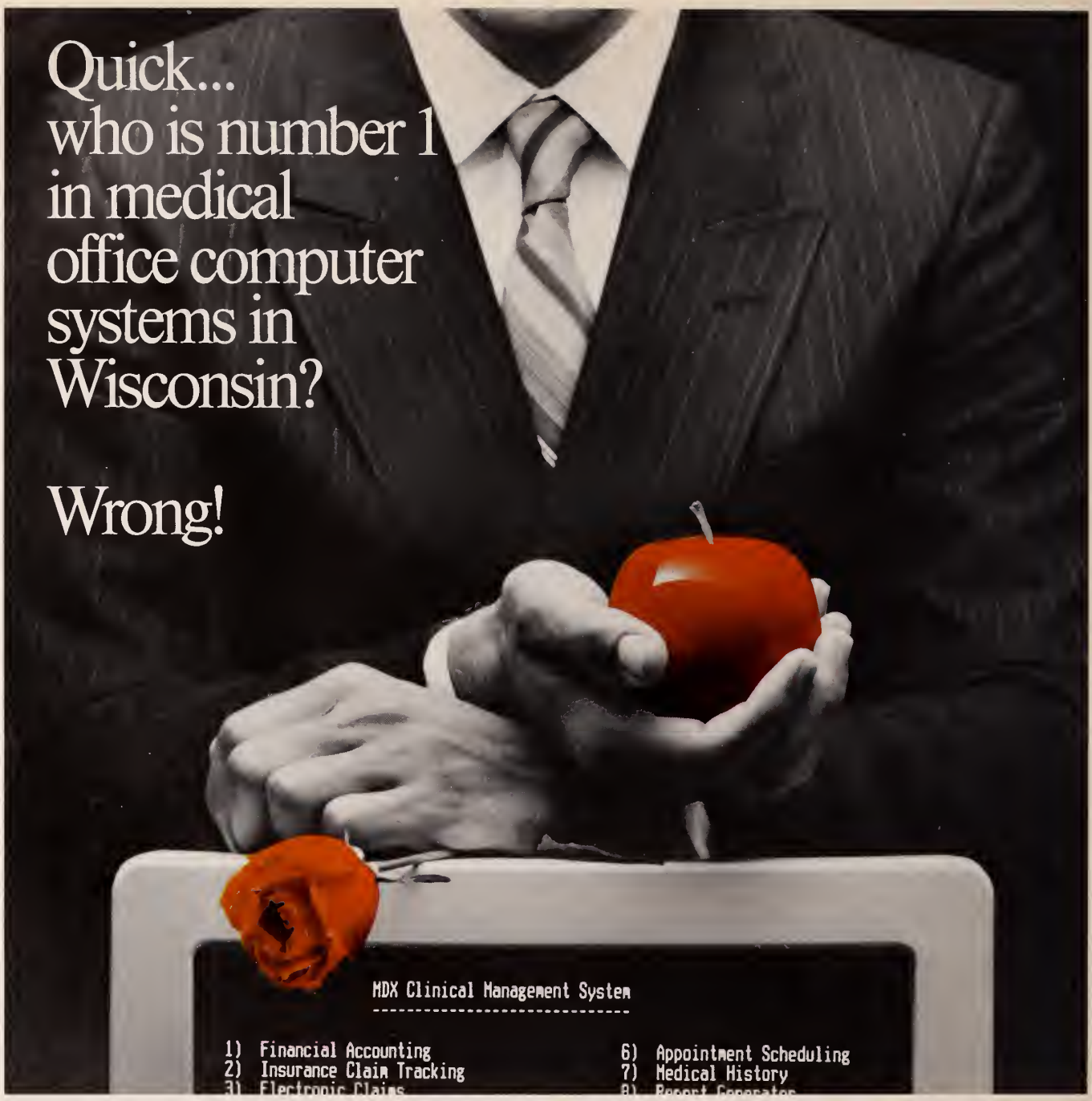

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RX for a busy physician

John K Scott, MD

THE PHYSICIAN is only nature's assistant/Galen. Never go to one whose office plants look sick/Smallwood. The practice of medicine is an art, not a trade; a calling, not a business/Osler.

No man is more worthy of esteem than a physician who exercises his art with caution and gives equal attention to the right and the poor/Voltaire. Some people think doctors can put scrambled eggs back into the shell/Canfield. Much are we beholden to physicians who only prescribe the bark of the quinquina when they might oblige their patients to swallow the whole tree/Dalrymple. The doctor must have at his command a ready wit as dourness is repulsive both to the healthy and the sick/Hippocates.

A physician is a person who works sixteen hours a day telling others to slow down or they'll get high blood pressure; a doctor is a person who still has his tonsils, adenoids and appendix; obstetricians are doctors whose cases come out well even when they're delayed on the golf course; a specialist is a doctor who trains his patients to become ill only during office hours; patient's rule: it is not a matter of life and death, it's much more important than that/Anonymous.

The physician cannot prescribe by letter, he must feel the pulse/Seneca. He who conceals his ills cannot expect to be cured/Proverb. It is far better to cure at the beginning than at the end/Persius.

Surgery does the ideal thing, it separates the patient from the disease/Clendening. Good medicine always tastes bitter/Confucius. The best doctors in the world are Doctor Diet, Doctor Quiet, and Doctor Merryman/Swift.

I wonder why ye can always read a doctor's bill an ye never can read his purscription/Dunne. One reason physicians can be so happy about their work is the feeling of security their patients give them/Spencer. How ill the doctor fares, if none fare ill but he/Philemon.

A rule of thumb in the matter of medical advice is to take everything any doctor says with a grain of aspirin/Ace. One of the chief objects of medicine is to save us from the natural consequences of our vices and follies/Mencken.

REP 1 2 3 4 5 6 PRN

SIG: READ TWICE DAILY AS NEEDED TO RELIEVE TENSION.

_____ M.D.

Generic substitution not permitted

With all the frustrations facing physicians today, I thought in the President's Page I would add a bit of levity and common sense to our daily routine. After reading the above, sit back and think how common sensical our ancestors were. Not bad advice to help all of us travel the bumpy road of frustrations together!■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

Saving more money in MoTown

THE PATIENT HAD a breast tumor that clinically appeared to be malignant. This was confirmed by mammography. Her insurance coverage required a call to Detroit. It is only fair at this point to comment that the response of operators has been cut down from a 45-minute wait to quite a prompt response.

It was explained to the operator that the patient was to be scheduled for a breast biopsy and frozen section and that it was anticipated that this would be followed by more definitive surgery. At the mention of the words "breast biopsy," the operator said that according to her book this was an outpatient procedure and hospital admission was denied. It was explained that further surgery was undoubtedly to follow and the operator finally said this called for a conference. Later in the day, a sympathetic Detroit general surgeon called and reiterated that the patient could not be admitted to the hospital for breast biopsy no matter what else was planned. He suggested three alternatives. The first was to proceed with the biopsy under general anesthesia to be followed by frozen section and then discharge the patient from the hospital. At some later date the more definitive surgery could be carried out, even though this would involve a second anesthetic, second operating room charge, a second recovery room charge, and whatever else goes into the hospital adding machine. The second alternative was to perform the initial procedure, then wake the patient and discuss the situation with her, and then call Detroit. This discussion with a groggy, recently anesthetized patient might prove to be a little hazardous in a legal confrontation. The third alternative, and the one which was selected, was to proceed with the biopsy and frozen section and after the pathologist had rendered his decision, to have someone call Detroit and request permission to admit the patient to the hospital. This was done and the response from Detroit was "do you have a second opinion?" The representative of the surgeon allowed that the diagnosis by the pathologist from the frozen section could constitute a valid second opinion.

On the first postoperative day the surgeon and the patient's husband received letters from the insurance carrier denying hospital admission on the basis of the original request. Also noted were the dire consequences and appeal procedures. By the time the patient was discharged from the hospital on the fourth postoperative day, there was still no formal permission to admit the patient to the hospital.

What a waste of time (and money), what a frustrating situation, and what a way to have to practice medicine!

—*Victor S Falk, MD,* Edgerton

Irradiated foods

THE AMERICAN COUNCIL on Science and Health recently published a report on the irradiation of foods. The process has been studied by American scientists for more than 40 years, but most Americans are unfamiliar with the subject and the safety of irradiated foods.

Irradiation is the use of ionizing radiations on food and does not make the food radioactive. Irradiation is currently used to sterilize more than 30 percent of the sterile disposable medical devices used in the United States. The same technique can also be applied to foods. A high-dose irradiation treatment can kill all the microorganisms that might grow in food, and sterilized food can be stored in sealed containers for years at room temperature without being spoiled by microorganisms. Radiation-sterilized foods are not yet commercially available in the United States, but they have been enjoyed by astronauts and by some hospital patients who are confined to special sterile environments.

Processes that decrease the number of microorganisms in food without completely sterilizing it have many uses. The pasteurization of milk is one example as it destroys any disease-producing microorganisms that might be present in milk and delays spoilage by greatly reducing the number of spoilage microorganisms. Radiation also can delay the spoilage of highly perishable fresh fish and shellfish, reduce the number of microorganisms in spices, destroy some types of disease-causing bacteria and parasites, and extend the shelf life of fruits such as strawberries by delaying mold growth. This has little or no effect on flavor. In the future, it is possible that the pasteurization-type treatment may be used to ensure the safety of fresh meat and poultry since these foods are frequently contaminated by microorganisms such as Salmonella.

Low-dose irradiation can kill insects in grains and other stored food and could be substituted for the fumigant ethylene dibromide which is now banned. The radiation would facilitate the interstate and international shipment of

fruits and vegetables where such shipment is now often prohibited. This would apply to such situations as the Mediterranean fruit fly infestations in California and Florida.

A very low-dose irradiation treatment inhibits sprouting of vegetables such as potatoes, onions, and garlic and can replace chemicals currently used for this purpose. It also delays the ripening and extends the shelf life of fruits such as bananas, mangos, papayas, guavas, and avocados. A low-dose of radiation can also eliminate the potential hazard of trichinosis in fresh pork. The irradiation treatment works by sexually sterilizing *Trichinella spiralis,* the parasite that causes trichinosis, so that it cannot mature. There are about 100 cases of trichinosis transmitted by commercial pork in the United States each year.

Irradiation does not make the food radioactive and the irradiation does not generate radioactive waste. At least 28 countries have approved some application of radiation.

In 1984 the American Medical Association sent a letter to Congress stating that food irradiation is safe, may be an important substitute for pesticides, and can control bacterial contamination of some foods. In the United States, irradiation has been approved for three specific purposes: sprout inhibition of white potatoes, insect disinfestation of wheat and wheat flour, and control of microorganisms and insects in spices and other seasonings. The FDA has proposed permitting the irradiation of fruits and vegetables to "inhibit growth and maturation" (i.e., prevent sprouting, delay ripening); permit irradiation of any food for the purpose of insect control; and permit irradiation of foods within certain limits if it could be shown that irradiation would accomplish its intended purpose. Also it would no longer require irradiation to be declared on retail food labels.

The Americal Council on Science and Health concluded that the irradiation could have many benefits for U.S. consumers by increasing the variety of techniques that can be used to provide a safe, wholesome convenient food supply and that the proper use of food irradiation does not present a health hazard.

—*Victor S Falk, MD,* Edgerton ■

Are you prepared when severe

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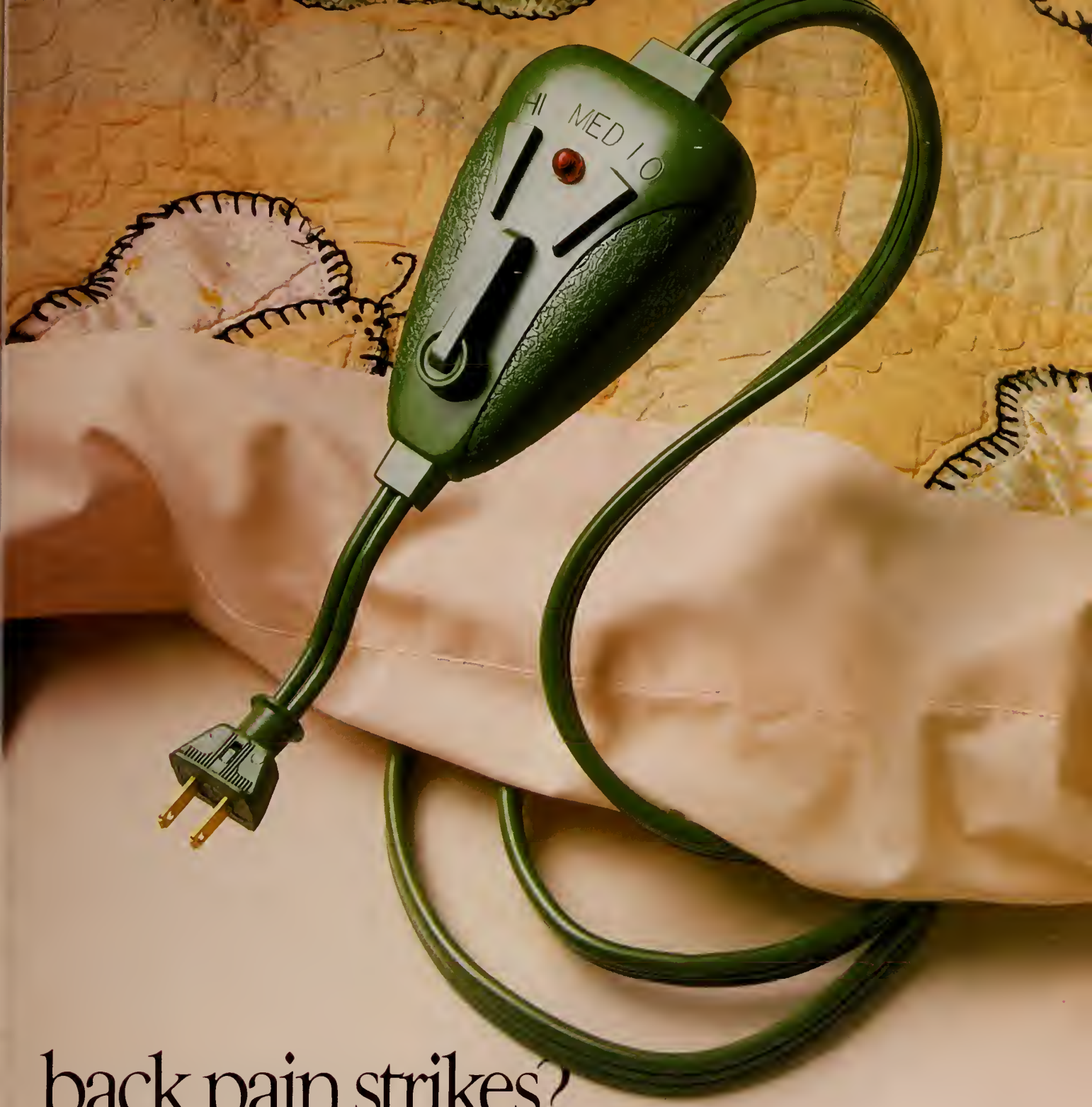

back pain strikes?

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The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

An overview of the Medical Examining Board

TO THE STATE MEDICAL SOCIETY: The Medical Examining Board has been the subject of some interest from many sources over the recent months. In order to bring about a better understanding, the Board prepared a comprehensive overview of its operations. (Copies were sent to the Governor, Legislature, Media, and Public. It is being published below at the request of the Board of Directors.) Some highlights of the report are as follows:

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- The Board's responsibilities cover a broader spectrum than just discipline.
- Due process in disciplinary matters is required, and should be a guaranteed right of all citizens, but it hinders the timely disposition of cases.
- Additional personnel are necessary to expeditiously investigate and prosecute alleged incompetent licensees of the Board.

We hope this overview addresses some of the concerns leveled at the Board. If additional information is desired, please feel free to contact a member of the Medical Examining Board listed below:

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1400 East Washington Avenue
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Madison, Wisconsin 53708
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* * *

IN THE RECENT months, there has been much interest from the public, the media and the Legislature, regarding the functions of the Medical Examining Board. The members of the Medical Examining Board have been concerned that the public is not fully aware of responsibilities or how these responsibilities are accomplished.

The duty of Medical Examining Board is the protection of the public. Interest is centered most recently in discipline of physicians who are guilty of unprofessional conduct. This, however, is not the only statutory responsibility of the Board.

Who are the members of the Medical Examining Board?

The current Board is composed of ten members, two citizen members and eight physicians, one of whom is a Doctor of Osteopathy. The members are nominated by the Governor and appointed with the advice and consent of the Senate to four year terms. A Board member may serve a maximum of two terms. The current Board members' specialties include: internal medicine, family practice, general surgery, psychiatry and pediatrics. No member of the Medical Examining Board may be an officer in a private organization which promotes that profession.

What are the Medical Examining Board's responsibilities?

The responsibilities of the Medical Examining Board include licensing and disciplining the professionals under its jurisdiction, proposing statutes to help with that process, serving as advisors to the Governor and Legislature, establishing standards of conduct, and promulgating rules to administer the statutes. The Medical Examining Board has under its jurisdiction, physicians, podiatrists, physical therapists, and physician assistants. The

latter three groups have advisory councils which report directly to the Medical Examining Board.

When are the meetings?

The Board has twenty meeting days per year—a full working month. The meetings average nine to ten hours per day, often extending into the evening. The per diem reimbursement for this is twenty-five dollars per day.

In addition, each Board member is involved with a standing committee, which meets 4-6 full days per year. A Board Member's responsibilities include testimony before the legislative committees and presentations to citizen groups throughout the state. Several Board members hold posts in The National Federation of State Medical Boards and related organizations.

Who is granted a license to practice medicine?

Before being considered for a license to practice medicine, a candidate must have finished college and medical school at accredited institutions. He or she must have completed an internship, and must have passed a series of examinations documenting basic general knowledge in all fields of medicine.

Each must then pass an oral examination before the Board. Approximately 800 physicians are newly licensed to practice Medicine and Surgery in Wisconsin each year.

The oral examination: Only six states require some type of oral examination. The members of the Wisconsin Examining Board feel strongly that the oral examination has merit. The examination identifies a number of individuals whose deficiencies have been sufficiently questionable that they constitute a clear danger to the health, welfare and safety to Wisconsin's citizens. If there were no oral examination, these individuals would have been licensed, since their other credentials were in order. It is much easier to not let them start practicing at all, than to find they are not knowledgeable after they have been practicing for some time. An example of how useful this is involves the recent scandals about a few foreign medical schools. Since each candidate has to appear in person and discuss his or her basic medical knowledge, it would be much more difficult for a person who has fraudulent credentials to be licensed in a state which gives oral examinations. This is an added safeguard for the people of Wisconsin in the licensing of physicians.

Five of our twenty meeting days are spent in administering individual oral examinations. Only the physician members of the Board can directly examine licensee applicants since the questions primarily deal with clinical medicine. Other areas tested are good knowledge of prescriptive practices with regards to controlled substances such as narcotics, understanding of the statutes and rules regarding the practice of medicine in Wisconsin and communications skills. Each oral examination requires fifteen to thirty minutes. At times there may be 200 to 250 applicants on each examination day. Because of the Medical Examining Board's need to free up time for other critical matters, qualified physicians already licensed in Wisconsin, are screened and hired at a nominal fee to assist with oral examinations. It is hoped that in the future there will be an adequate number of non-Board physicians to assume the full responsibility of examining licensee applicants. If applicants fail the oral examination, they will then have to be examined by the entire Medical Examining Board. If applicants fail the oral examination a total of three times, the Board will require that additional postgraduate training be taken. Approximately two to four percent of physicians fail the examination the first time they take it.

Discipline:

Disciplinary measures involve a major segment of the Board's time at each meeting. Physicians are subject to discipline when they commit unprofessional conduct as defined by the statutes and rules of the Board. The rule most often cited is the "danger rule", recently defined by the Wisconsin Supreme Court as "that practice which constitutes a danger to the health, welfare, and safety of a patient by failing to meet the level of minimal competence established in the profession and by posing unacceptable risks which a minimally competent licensee would have avoided or minimized."

Any citizen can register a complaint against a physician. There is protection from civil liability from those who, in good faith, provide information to the Board concerning possible unprofessional conduct. All cases from the Patient Compensation Panel in which negligence is found are automatically referred to the Medical Examining Board for review. A finding of negligence by the PCP must rise to the level of unprofessional conduct as defined in the statutes. Cases in which a physician's hospital privileges have been restricted or suspended for more than 30 days are also an automatic Board referral. Moreover, a major area of discipline includes impaired physicians, those who have been practicing while impaired with drugs, alcohol, or mental illness. Physicians are reported who are practicing with physical or mental incapacity, also.

All complaints are assigned to a Division of Enforcement attorney and investigator and a member of the Medical Examining Board, who serves as the Board Advisor. The Board member functions to give medical and consumer expertise in advising the investigators and attorneys on facts related to medicine. All of the facts, including testimony of the plaintiff and witnesses, patient hospital records and Patient Compensation Panel depositions are

reviewed by a Board member on his or her own time. These case reviews constitute a majority of the many hours of "homework" that are required of each Board member. This may average forty to sixty hours between Board meetings.

The investigation is handled by investigators from the Division of Enforcement in the Department of Regulation and Licensing.

Right now, there are 2.75 full-time equivalent investigators assigned to the Board.

Once the investigation is completed, the Board advisor decides if there is merit to the charge of unprofessional conduct. If the Board member feels that unprofessional conduct occurred he or she recommends that the case be taken to public hearing. The statutes allow the Board to reprimand, suspend, revoke, or limit a license.

There is much emphasis on due process in all of the handling of disciplinary cases and during the hearing process. Expert witnesses are hired to review the cases and give testimony. A hearing examiner hears the case and renders a decision, which includes findings of fact, conclusions of law and order regarding discipline.

The hearing examiner is an attorney in the Department of Regulation and Licensing. He or she has all the rights of a judge. Once the Board issues a formal complaint against a physician, the hearing examiner schedules the date of the hearing. The hearing examiner at that point may issue postponements, take depositions, consider motions and handle all other aspects of the hearing. The Board has no input on expediting the matter once the formal complaint has been issued varies from three months to three years.

At present, the Medical Examining Board has only one hearing examiner, who also has other responsibilities. He is hearing examiner for six other boards and legal counsel to seven other boards.

The prosecuting attorneys are supplied to the Board by the Department of Regulation and Licensing.

At present, there are 2.1 full-time equivalent attorneys. This is, three attorneys spend part of their time on Medical Examining Board cases. Each attorney has a backlog of approximately twenty cases in which complaints have been issued and they are waiting to go to hearing. Each attorney can take only five or six cases per year to hearing.

Once the order has been issued from the hearing examiner, the case is then brought back to the Board for approval. If the defendant disagrees with the Board's decision, the defendant may appeal to the courts for review. While there is strict adherence to due process, such a process may lead to a delay in the resolution of a case. One case has gone to the Supreme Court in the appeal process. From the time of the Board's initial decision, until it got to the high court, took three years.

If the Board member feels that there is no merit to a complaint, the case is presented to the entire Board for approval of the case being closed. On occasion, Board members have disagreed with the Board advisor and have advised taking the case to public hearing. The Board may close a case based on lack of evidence or prosecutorial discretion. Because of a lack of staff, more cases are closed without formal hearing than desireable. These are low-priority cases which deal with problems that do not present a clear danger to the public or involve physicians who are no longer practicing in this state. The Medical Examining Board acknowledges the possible merit of these cases, but to pursue them would prevent dealing with more serious cases.

There is a backlog of 350 pending complaints. It takes a minimum of eighteen months for a case to reach final disciplinary action and it frequently takes longer than eighteen months. Even if the case is closed for lack of evidence, twelve months have often elapsed. Needless to say, this is a major impedance to expediting the entire disciplinary process.

Other responsibilities.

Additional Board time is involved in regular meetings with impaired physicians who have been given limited licenses, requiring oversight of their progress. Many of these individuals appear before the Board two times per year.

Moreover, the Board receives many inquiries concerning the practice of medicine or interpretation of statutes and rules governing the practice of medicine and the Board must respond to these.

The Medical Examining Board is available to the Legislature for consultation on proposed legislation. From time to time, the Board may pursue legislation or promulgate rules to implement existing statutes.

Patient Compensation Panel cases.

A number of issues face the Medical Examining Board. Perhaps the most controversial involves Patient Compensation Panel cases. At present, the Medical Examining Board receives all cases in which negligent acts have been found by the Panel. The Board agrees that there are some acts of negligence that are so serious that the physician should receive official Board discipline. However, there are some acts of negligence that do not necessarily fall below the "minimal competency" standard.

Also, some of the patient compensation awards are made on the basis of "sympathy verdicts" on the part of the Panel when no significant mistake has been made on the part of the physician despite the fact that there was a bad result.

To take all of these cases to hearing indiscriminately would impede the handling of the cases of more serious import. Automatic referral of all malpractice claims would also hopelessly encumber the system. The Board agrees that it is important to review all cases settled without Patient Compensation Panel hearings, since such settlements allow the deficient physician to hide from public scrutiny. If such comprehensive reviews are mandated, the work load would increase substantially. A more expeditious way of reviewing these cases must be developed. The main asset in having all of these cases referred to the Board is to allow the Board to be aware of patterns in practice. An inordinate number of malpractice cases, even if each in and of itself does not fall below the minimum standard, indicates that a person's practice should be investigated, as the pattern developed may fall below the minimum standard.

Public members (non-physician members of the Examining Board).

There is a current proposal to expand the number of citizen members. While citizen members provide valuable input for Board decision-making, physicians are needed to critically assess most of the quality-of-care issues that are raised in disciplinary complaints. As the case load increases, more physicians will be needed in this vital review process.

While the Medical Examining Board supports the trend to have more citizen participants on all regulatory boards, it is recommended that the professional membership of the Board not be decreased.

What, then can be done to improve the discipline process?

It is critically important to hire more attorneys, investigators, hearing examiners and ancillary staff to deal with the current backlog and future increased workload. While a temporary contract with a private firm will assist with the backlog, it will not be a long term solution for future workload increases. The number of cases each Board member now reviews is manageable, but will exceed the capacity of the Board members to be the only reviewers in the future. The Medical Examining Board might consider a contract with private physicians for initial case reviews. However, those cases initially determined to be without merit would still have to come before the full Board for closure.

It is recommended that all well-trained witnesses in the Medical Examining Board proceedings be guaranteed immunity from civil liability. This would encourage more witnesses to participate in the process.

When a physician is an immediate and grave threat to patients, the Medical Examining Board may suspend his license for sixty days prior to holding a hearing. The Medical Examining Board recommends a statutory amendment to extend this suspension beyond 60 days, until the final order regarding his license is adopted by the Medical Examining Board.

The Medical Examining Board realizes that the public's perception is that they are not completing our tasks in a timely fashion. However, they wish to emphasize that the Medical Examining Board has many statutory responsibilities. It is also unfortunate that the public is not aware of the countless and often unrecognized hours of volunteer service given by the Board member.

The delays per se are actually beyond the control of the Medical Examining Board members. The Board has been asking for more staff for three years without any changes having been made. They cannot accomplish their assigned task without being given the personnel to do the job.

In this summary, we have tried to describe the Medical Examining Board's composition and responsibilities. It is hoped that the public can also become aware of the operating processes and solutions that are seen as imperative in allowing the Board to accomplish the task of protecting Wisconsin citizens.■

70th Scientific Assembly

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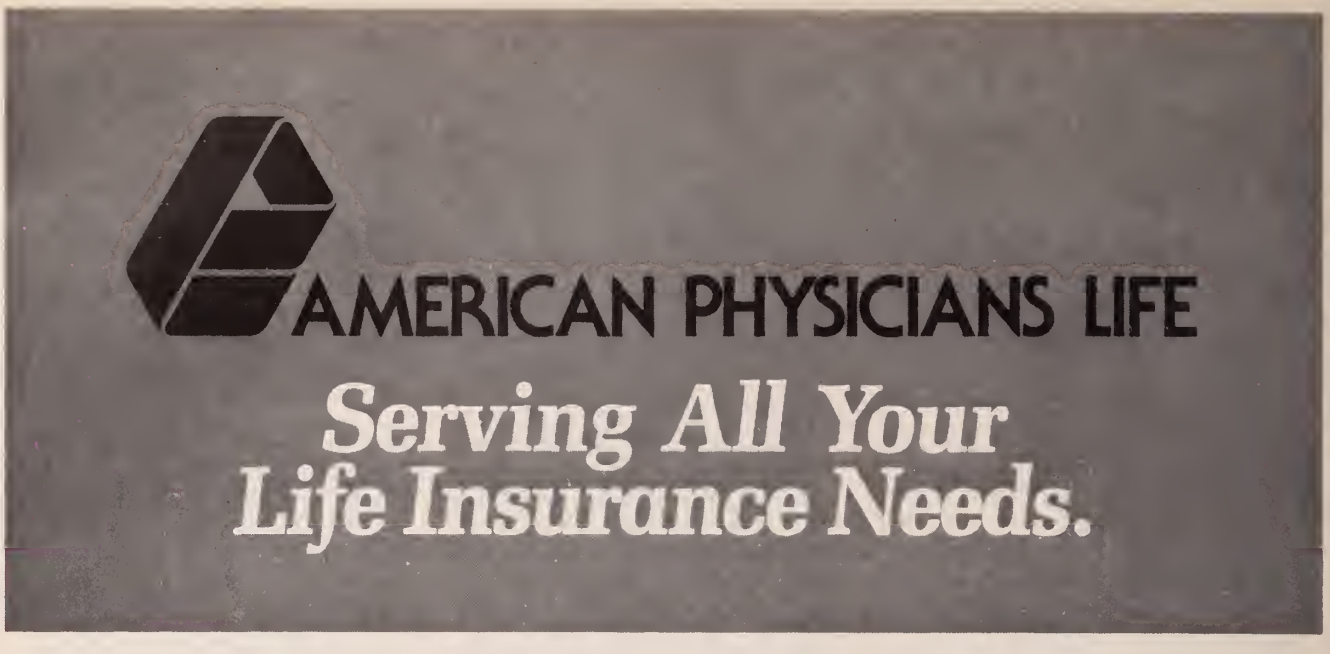

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Replantation for ring avulsion injuries

Venkat K Rao, MD and *Robert S Feins, MD,* Madison, Wisconsin

ABSTRACT. *Ring avulsion injuries are difficult to treat. The options are replantation or amputation. Four cases are presented and the results by replantation shown. Replantation is recommended for these injuries whenever feasible.*

Key words: Hand injuries; Microsurgery; Replantation; Avulsion injuries.

RING-AVULSION INJURIES—degloving or tearing away the soft tissue of the finger—commonly occurs when a wedding band or ring is caught on a sharp edge or object. Although the ring finger is most commonly involved, this injury also occurs to the little finger. The treatment of this injury has changed with the availability of increasingly sophisticated microsurgical techniques.

Ring avulsion injuries have been classified according to severity:[1]

CLASS I: Skin and soft tissue injury with the retention of adequate circulation.

CLASS II: Some intact soft tissue without adequate circulation.

CLASS III: Complete amputation.

Class III injuries typically involve avulsion at the level of the ring and disarticulation of the distal interphalangeal (DIP) joint.

From the Replantation Service, Division of Plastic and Reconstructive Surgery, University of Wisconsin Medical School, Madison. Publication support provided. Reprint requests to: Venkat K Rao, MD, Division of Plastic Surgery, 600 Highland Ave, Madison, Wis 53792 (ph 608/263-1367). Copyright 1985 by the State Medical Society of Wisconsin.

Class II and Class III injuries may be treated by amputating or replanting the affected digit.[2-5] This report discusses the management of four severe Class II and Class III ring-avulsion injuries.

Material and methods. From August 1982 to August 1984, four patients with ring avulsion injuries were treated by the University of Wisconsin Replantation Service. Alternative treatments, including amputation and replantation, were discussed with the patients. All the patients desired replantation.

Case reports. *Case 1.* This was a 39-year-old woman whose wedding ring caught on an edge when she fell from a boat dock. The injury resulted in a Class III avulsion of the ring finger of the nondominant hand and disarticulation at the DIP joint (Fig 1). The extensor tendon remained intact, but the flexor digitorum profundus tendon was avulsed from the musculotendinous junction. Replantation was performed with vein grafts and primary nerve repair. After the operation, the finger was examined hourly and skin temperature was monitored with a probe. The patient had an uneventful recovery and started occupational therapy four weeks after the operation (Figs 2, 3).

Case 2. This was a 40-year-old farmer who caught his left ring finger in a farm machine and suffered a Class III avulsion. Replantation was performed without vein grafts, and the patient

Table 1—*Summary of patients*

Patient	*Age*	*Class*	*Use of vein grafts*	*Success*
1	39	Severe II	+	+
2	40	III	–	–
3	30	Severe II	+	+
4	21	III	+	+

Table 2—*Active range of motion*

Patient	*Joint* and range of motion (degrees)*		
	MP	*PIP*	*DIP*
1	0-95	10-100	40-40
2	0-95	—	—
3	0-85	35-100	20-20
4	0-95	35-100	20-20

*Metacarpophalangeal (MP), proximal interphalangeal (PIP), distal interphalangeal (DIP)

did well until the second postoperative day when finger temperature decreased. Reexploration revealed a clotted arterial anastomosis. A vein graft was harvested and interposed, but blood flow could not be reestablished, and the finger was amputated at the proximal phalanx. The patient made a good postoperative recovery, but he has difficulty grasping small objects, such as coins, because of the gap in the hand secondary to the amputation.

Case 3. This was a 30-year-old truck driver who leaped from the back of a truck and caught his ring on an edge, suffered a degloving injury with near total avulsion of the finger (Class II) (Fig 4). The degloved finger was replanted with vein grafts and primary nerve repairs. The patient did well and began occupational therapy four weeks after the operation (Figs 5, 6).

Case 4. This was a 21-year-old man who caught his left ring finger in a fence when he jumped from a farm machine. The accident resulted in complete avulsion of the ring finger (Class III). Replantation was performed with vein grafts, primary nerve repairs, and the fusion of the DIP joint. The patient made an uneventful recovery and began occupational therapy four weeks after the operation.

Results. Table 1 summarizes the patient population, severity of injury, and outcome of replantation.

Each patient recovered quite well; the active range of motion of the affected digit, after occupational therapy, is summarized in Table 2.

There was no return of motion at the DIP joint because the flexor digitorum profundus tendon was not repaired (Table 2). All patients had a normal range of motion at the MP joint and a varying range of motion at the PIP joint. The patient whose finger was amputated reported difficulty in grasping small objects, a problem related to the gap left between the fingers. Sensibility in all patients, measured by two-point discrimination, was about 10 mm.

Discussion. Ring-avulsion injuries are difficult to treat. Usually the soft tissue of the finger is degloved from the tendons or bones. Although tempting, a flap or skin graft will not be useful and should be avoided. Thus, the only two choices of treatment are primary amputation and replantation.

A successful replant, measured by finger viability, is difficult for ring-avulsion injuries. The major obstacle to success is the high incidence of vascular thrombosis that results from more extensive intimal damage than is initially recognized under the operating microscope. Long segments of the digital arteries and veins must be debrided, and the defect must be bridged with vein grafts.

The severe trauma of ring avulsion usually precludes a full range of motion for the injured

Preparation and preservation for transplantation

What type of patients

Patients with clean cut, crush or avulsion amputations of the following are candidates for replantation:

- Thumb
- Single or multiple fingers
- Major extremities such as arms or legs
- Scalp, facial, or penile avulsions
- Severe hand injuries

How to prepare and preserve parts

Cooling the amputated part lengthens the time the part remains replantable. If the part is warm, it may last only up to 12 hours (for digits) and up to 8 hours (for limbs). To cool body parts:

- Wrap part in moist, sterile gauze or towel
- Place in plastic bag or other container
- Put container on ice for transport
- Do not use dry ice, or allow part to freeze

Early, successful surgery depends on rapid transport!

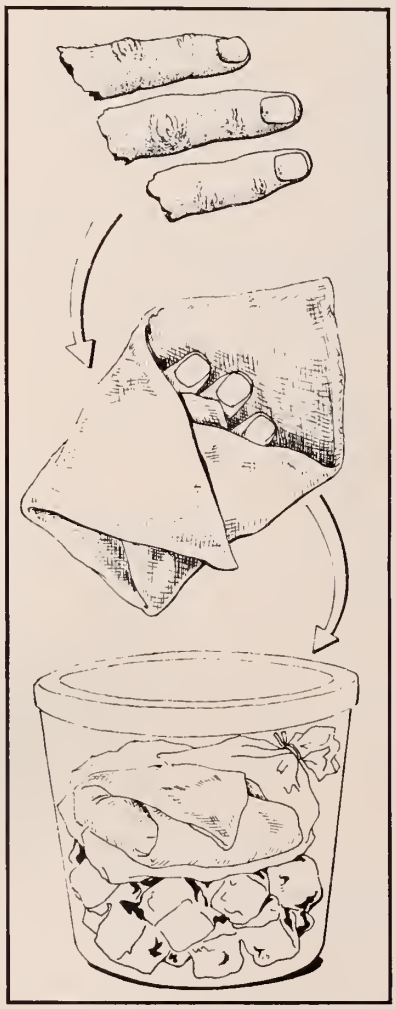

Figure 1—*Ring avulsion injury.*

Figure 2—*Palmar view nine months postoperatively.*

Figure 3—*Dorsal view nine months postoperatively.*

Figure 4—*Class II ring avulsion injury (note ring).*

Figure 5—*Dorsal view nine months postoperatively.*

Figure 6—*Finger flexion nine months postoperatively.*

finger. However, because the ring finger is not a border digit, the lack of full range of motion in the presence of good MP motion and moderate PIP motion does not appreciably impair hand function. Besides disfigurement, primary amputation at the metacarpophalangeal joint or proximal phalanx usually causes difficulty in grasping small objects in the palm of the hand. This disability can be treated with a ray resection, but it results in decreased grip strength, because of the decreased palm width.

Replantation for ring avulsion injury produces a satisfactory functioning digit and should be considered a more desirable option than primary amputation.

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NIH Consensus Development Conference

Lowering blood cholesterol to prevent heart disease

Earlier this year the National Heart, Lung, and Blood Institute and the Office of Medical Applications of Research of the National Institutes of Health (NIH) held a Consensus Development Conference on *Lowering Blood Cholesterol to Prevent Heart Disease.* After hearing presentations on the subject by scientific experts, a consensus panel issued a report containing conclusions and recommendations concerning lowering blood cholesterol. Free, single copies of this consensus statement are available from: Michael J Bernstein, Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 216, Bethesda, Maryland 20205. Published below are the Panel's conclusions:

Elevated blood cholesterol level is a major cause of coronary artery disease. It has been established beyond a reasonable doubt that lowering definitely elevated blood cholesterol levels (specifically blood levels of low-density lipoprotein, cholesterol) will reduce the risk of heart attacks due to coronary heart disease. This has been demonstrated most conclusively in men with elevated blood cholesterol levels, but much evidence justifies the conclusion that similar protection will be afforded in women with elevated levels.

After careful review of genetic, experimental, epidemiologic, and clinical trial evidence, we recommend treatment of individuals with blood cholesterol levels above the 75th percentile (upper 25 percent of values). Further, we are persuaded that the blood cholesterol level of most Americans is undesirably high, in large part because of our high dietary intake of calories, saturated fat, and cholesterol. In countries with diets lower in these constituents, blood cholesterol levels are lower, and coronary heart disease is less common.

There is no doubt that appropriate changes in our diet will reduce blood cholesterol levels. Epidemiologic data and over a dozen clinical trials allow us to predict with reasonable assurance that such a measure will afford significant protection against coronary heart disease.

For these reasons we recommend that:

1. Individuals with *high-risk blood cholesterol levels* (values above the 90th percentile) be treated intensively by dietary means under the guidance of a physician, dietitian, or other health professional; if response to diet is inadequate, appropriate drugs should be added to the treatment regimen. Guidelines for children are somewhat different, as discussed below.

2. Adults with *moderate-risk blood cholesterol levels* (values between the 75th and 90th percentiles) be treated intensively by dietary means, especially if additional risk factors are present. Only a small proportion should require drug treatment.

3. All Americans (except children under 2 years of age) be advised to adopt a diet that reduces total dietary fat intake from the current level of about 40 percent of total calories to 30 percent of total calories, reduces saturated fat intake to less than 10 percent of total calories, increases polyunsaturated fat intake but to no more than 10 percent of total calories, and reduces daily cholesterol intake to 250 to 300 mg or less.

4. Intake of total calories be reduced, if necessary, to correct obesity and adjusted to maintain ideal body weight. A program of regular moderate-level exercise will be helpful in this connection.

5. In individuals with elevated blood cholesterol, special attention be given to the manage-

ment of other risk factors (hypertension, cigarette smoking, diabetes, and physical inactivity).

These dietary recommendations are similar to those of the American Heart Association and the Inter-Society Commission for Heart Disease Resources.

We further recommend that:

6. New and expanded programs be planned and initiated soon to educate physicians, other health professionals, and the public to the significance of elevated blood cholesterol and the importance of treating it. We recommend that the National Heart, Lung, and Blood Institute provide the focus for development of plans for a National Cholesterol Education Program that would enlist participation by and contributions from all interested organizations at national, state, and local levels.

7. The food industry be encouraged to continue and intensify efforts to develop and market foods that will make it easier for individuals to adhere to the recommended diets and that school food services and restaurants serve meals consistent with these dietary recommendations.

8. Food labeling should include the specific source or sources of fat, total fat, saturated and polyunsaturated fat, and cholesterol content as well as other nutritional information. The public should be educated on how to use this information to achieve dietary aims.

9. All physicians be encouraged to include whenever possible a blood cholesterol measurement on every adult patient when that patient is first seen; to ensure reliability of data, we recommend steps to improve and standardize methods for cholesterol measurement in clinical laboratories.

10. Further research be encouraged to compare the effectiveness and safety of currently recommended diets with that of alternative diets; to study human behavior as it relates to food choices and adherence to diets; to develop more effective, better tolerated, safer, and more economical drugs for lowering blood cholesterol levels; to assess the effectiveness of medical and surgical treatment of high blood cholesterol levels in patients with established clinical coronary artery disease; to develop more precise and sensitive noninvasive artery imaging methods; to apply basic cell and molecular biology to increase our understanding of lipoprotein metabolism (particularly the role of HDL as a protective factor) and artery wall metabolism as they relate to coronary heart disease.

11. Plans be developed that will permit assessment of the impact of the changes recommended here as implementation proceeds and provide the basis for changes when and where appropriate. ■

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ABSTRACT

Microscopically controlled surgery for periorbital melanoma: fixed-tissue and fresh-tissue techniques

FREDERIC E MOHS, MD, Chemosurgery Clinic, Department of Surgery, University of Wisconsin Hospital and Clinics, Madison, Wis: *J Dermatol Surg Oncol* 1985 (Mar);11:284-291

Micrographic surgery for the microscopically controlled excision of malignant melanomas is especially useful around such important structures as the eyes because the method permits maximal sparing of normal tissues without jeopardizing the patients' chances of being cured. The tissue of the melanomatous area is excised layer by layer and the entire underside of each layer is scanned in the microscope to precisely locate the unpredictable outgrowths that may extend for a considerable distance beyond the clinically observed borders. The fixed-tissue technique, by which the tissues are subjected to chemical fixation in situ, is used for most periorbital melanomas. However, the fresh-tissue technique, followed by brief cauterization of the excisional surface with dichloroacetic acid is used for melanomas on the lid margins or bulbar conjunctiva because of the danger of the fixative damaging the eye in these areas. In addition to the certainty with which the primary melanoma is eradicated, the management of possible invisible satellites is improved since they are not disturbed, disseminated or covered with a graft or flap and they can be removed expeditiously when they become clinically visible.■

Old versus new antiparkinsonian agents?

Norman C Reynolds Jr, MD, Milwaukee, Wisconsin

ABSTRACT. ***Current medical treatment for patients with Parkinson's disease assists patients to regain or at least to maintain some degree of control in motor function as the disease progresses. In our search for more potent agents with greater effectiveness, many physicians have abandoned the use of older medications such as anticholinergic agents. In order to avoid fluctuations in motor performance and unwanted side effects of the newer, more potent agents, the author recommends a conservative medication program making use of both drugs with tonic effects (less potent) and drugs with phasic effects (more potent) on motor performance. Guidelines for the rational use of anticholinergic drugs as an integral part of an anti-Parkinson medication program are outlined.***

Key words: Parkinsonism; Antiparkinsonian agents

A NUMBER of new pharmacologic agents are being evaluated to improve motor deficiency aspects of Parkinson's disease. These include the aporphines,[1] lergotrile,[2] and mesulergine,[3] with bromocriptine[4,5] (Parlodel®) already released, first in 2.5 mg and more recently in 5.0 mg oral dosage forms. These new agents have direct dopamine receptor effects in the striatum, independent of the failing metabolic machinery of the dopamine producing neurons of the substantia nigra. The new agents provide a major hope for continuing therapy as dopaminergic neurons decline. Another major emphasis in newer agents is to provide some alternatives in reducing fluctuations in motor and mental performance, the "On-Off Effect." Rather than looking forward to a new solution for "On-Off Effects" or a new agent with sustained potency in the face of motor decline, doctors should consider a major step backwards to reestablish goals of more conventional treatment. In addition, the cost savings of older medications compared to the newer medications can be substantial.

The basis of conventional drug therapy relates to synaptic circuitry of nigrostriatal projections. The dopamine secreting inhibitory neurons in the substantia nigra are lost in the process of deterioration in the extrapyramidal motor system. The striatum loses its dopamine inhibitory control and is left with an imbalanced excitatory acetylcholine output (Fig 1). To rebalance, either anticholinergic drugs or dopamine agonists can be added to the circuit system with marginal to moderate improvement in motor control. This involves less bradykinesia, less rigidity, and more fluid movement in ambulation and facial expression. Improvement in tremor is often less than improvement in the other aspects of motor activity.

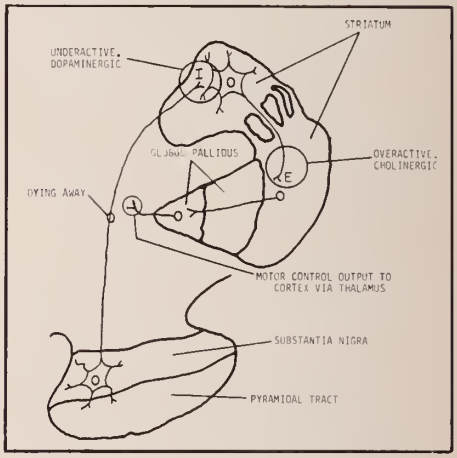

Figure 1—*Relationship of dopamine inhibition (I) and acetylcholine excitation (E) in extrapyramidal motor control.*

Since the loss of dopamine effects is the key element relating to motor disability, the use of L-dopa is a popular treatment mode.[6] As a metabolic precursor to dopamine, L-dopa by its very nature leads to fluctuations in central control. The phasic effects of L-dopa relate to metabolic conversion to dopamine by a decarboxylase enzyme. Levels of dopamine rise and fall with synthesis and use. Central neuronal decarboxylase provides synaptic dopamine while peripheral or systemic decarboxylase detracts from central levels by prematurely producing dopamine which cannot pass the blood-brain barrier. Toxic systemic side effects of L-dopa have been lessened considerably with the introduction of carbidopa in carbidopa/L-dopa combinations (*eg,* Sinemet®). As a peripheral systemic decarboxylase inhibitor, carbidopa allows rapid therapeutic central levels of L-dopa at lower doses. The central levels provide rapid therapeutic bene-

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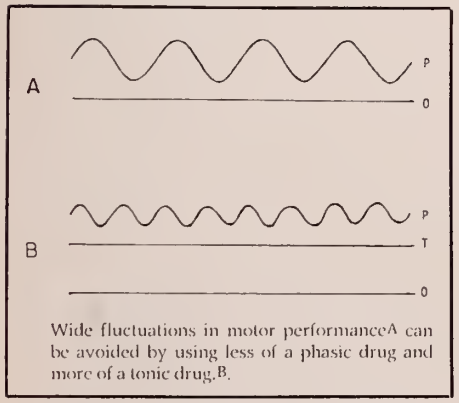
fits (20-30 minutes); however, such central effects last only three to four hours.

In an effort to provide maximal motor improvement, successive dosage increases of Sinemet® produce wider excursions in central levels and in associated motor performance in many patients. In some patients, transient high central levels of L-dopa lead to transient but annoying side effects or "On Effects." "On-Effects" of abnormal involuntary movements are frustrating to the patient but surpassed by the annoyance of "On-Effects" of hallucinations and delusions in susceptible individuals. "Off-Effects" occur when the central effects of Sinemet® fail to provide sustained improvement in motor control and typically occur before the next dose of Sinemet® is taken. The presence of "On-Off Effects" relating to the use of drugs with phasic effects like Sinemet® can be minimized by giving lower doses more frequently than every four hours (Fig 2).

Many of us are prescribing carbidopa/L-dopa (Sinemet®) and are looking forward to newer agents which report less fluctuations in performance. At the same time, a large number of us are overzealous about providing up-to-date and more potent agents and are ignoring some earlier and more conservative treatments. Prior to the advent of Sinemet®, the use of amantadine and numerous anticholinergic agents provided stable (albeit less potent) improvement on a twice daily dosage schedule. Although sustained improvement with amantadine (Symmetrel®) is typically lost as early as six months after its use, amantadine can be replaced with anticholinergic agents and reintroduced later for additional effectiveness when needed. The conservative use of agents like amantadine and anticholinergic drugs buys time for the patient and when combined with a mild to moderate exercise program can be effective for up to a few years before the addition of carbidopa/L-dopa becomes inevitable. The addition of phasic drugs at this time is superimposed on a higher level of control and need not be prescribed in doses which encourage fluctuations in performance or unnecessary "On-Effects" (Fig 2).



Wide fluctuations in motor performance[A] can be avoided by using less of a phasic drug and more of a tonic drug,[B].

Figure 2—*Tonic (T) and phasic (P) influences relative to untreated motor deficiency (O).*

On the other hand, patients already afflicted with "On-Off Effects" at moderate to high doses of carbidopa/L-dopa need a modification in their medication program. This should involve attempts at increasing tonic agents (*eg*, anticholinergic drugs) and decreasing phasic agents (*eg*, Sinemet®) and giving the latter more frequently at lower doses if necessary. Another alternative at this time is the addition of bromocriptine (Parlodel®) with later decreases in Sinemet® if mental changes or abnormal involuntary movements occur. Although bromocriptine (Parlodel®) is less phasic than Sinemet® and can be given two or three times a day, there are pre-synaptic inhibitory effects which limit the percentage of low dose (2.5 mg two or three times a day) responders to a small number. Typically effective doses are 40-60 mg in addition to the Sinemet® already being taken. Although the higher doses of Parlodel® provide adequate post-synaptic dopamine-like effects, the numbers of tablets required and their expense are often prohibitive.

Although the use of anticholinergic drugs is an older treatment mode, a variety of these drugs are available for use for more than one purpose (Fig 3). Neutral anticholinergic drugs can be used to provide a basic tonic improvement in motor performance without anti-psychotic or anti-anxiety effects. If psychotic or anxiety symptoms occur, the neutral agent can be replaced with an anticholinergic drug which also has mild anti-psychotic or anti-anxiety effects totally or at selected times. This is preferable to the use of benzodiazepines (*eg*, Valium®) which may retard motor performance and may encourage depression. Higher doses of Mellaril® or stronger neuroleptics (*eg*, Haldol®, Thorazine®, Prolixin®) which bind more avidly to the striatal dopamine receptors should be avoided since these reverse

NEUTRAL	ACTIVATING	ANXIOLYTIC/ ANTIPSYCHOTIC
Cogentin® 0.25–2.0 mg 2 times a day	Tofranil® 10–25 mg bedtime or 2 times a day	Benadryl® 25–50 mg 4 times a day as needed
Artane® 5 mg SA daily or 2.5 mg 2 or 3 times a day	Aventyl® 10–25 mg bedtime or 2 times a day	Parsidol® 10–50 mg 2 or 3 times a day as needed
	DEACTIVATING	
Akineton® 2 mg 2 to 4 times a day	Sinequan® 10–25 mg bedtime	Mellaril® 10–25 mg 2 or 3 times a day as needed

Figure 3—*Anticholinergic drugs.*

the positive effects of antiparkinson treatment. Occasionally certain individuals show an intolerance to anticholinergic drugs and may display an atropine-like psychosis or confusional state. In such cases only low doses may be tolerated. Reductions in phasic dopamine agonists should also be considered. If sleep is impaired with or without signs of depression, a dose of a neutral agent at bedtime can be replaced by low-dose doxepin (Sinequan®). If there is a low energy level during the day, low-dose imipramine (Tofranil®) can be used as a replacement agent for neutral anticholinergic drugs at bedtime or twice daily.

Although the search for newer agents has merit, a major step backwards to reconsider effective use of older agents also has merit. Because a number of patients display an intolerance to anticholinergic medication, low starting doses are recommended (Fig 3). A conservative treatment plan can postpone or even totally avoid the added burden of ineffective high doses of agents (*eg*, Sinemet®) which may beset the patient with fluctuations in performance and untoward mental effects.

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Tuberculous otomastoiditis

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ABSTRACT. ***The incidence of pulmonary tuberculosis and related tuberculous infections has markedly decreased in the United States. However, patients such as the one reported here are still seen on occasion with tuberculous otomastoiditis. This condition should be considered in any patient with a chronically draining ear that does not respond to antibiotic therapy. Patients with tuberculous otitis media frequently develop severe hearing loss and facial paralysis. Therapy is primarily medical, although in selected cases surgery may be necessary.***

Key words: Tuberculosis; Otitis media; Mastoiditis

THE INCIDENCE OF tuberculosis has decreased in many areas of the United States to the point that some health agencies are cautiously reviewing the cost effectiveness of mass screening procedures in low risk settings.[1,2] The following case illustrates that *Mycobacterium tuberculosis* infection must be considered in the differential diagnosis of otitis media unresponsive to usual antibiotic therapy.

Case report. The patient was a 2355-Gm product of a normal full-term pregnancy. Her family had recently moved to the inner city of Milwaukee from rural Mississippi. She was first seen at 11 months of age with mild respiratory symptoms and a fever. Chest radiographic studies revealed a right perihilar infiltrate. A Tine test was interpreted as negative. When the patient was 14 months of age, her maternal aunt was discovered to have cavitary tuberculosis. At age 16 months, the patient developed a draining left ear which did not respond to adequate courses of amoxicillin, trimethoprim/sulfamethoxazole, and cefaclor. Culture of the drainage revealed mixed skin flora.

At 20 months of age, the patient was evaluated after an episode of vomiting and falling to the left. She was a small, alert 20-month-old child. There was a small amount of purulent drainage from the left ear. Pale tissue completely obscured the left tympanic membrane. There were no periauricular lymph nodes or sinuses, and few cervical lymph nodes. The right ear was normal. The remainder of the examina-

From the Departments of Otolaryngology (BHC, RSY) and Pediatrics (TBC, MJC) of the Medical College of Wisconsin, Milwaukee, and Milwaukee Children's Hospital, Milwaukee. Reprint requests to: Michael J Chusid, MD, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wis 53233 (ph 414/933-4295. Copyright 1985 by the State Medical Society of Wisconsin.

tion was normal. Laboratory studies revealed a hemoglobin level of 9.7 mg/dl, white blood cell count of 8100/μl^3 with a normal differential and an erythrocyte sedimentation rate of 74 mm/hour. The urinalysis was normal. Spinal fluid had three mononuclear cells/μl^3, a glucose of 63 mg/dl, and protein of 12 mg/dl. Chest radiographic studies showed an infrahilar infiltrate. A caseating granuloma was found in a biopsy of the tissue in the left ear canal. A 5 TU purified protein derivative (PPD) skin test had 25 mm of induration at 72 hours. Temporal bone tomography showed significant destruction of the ossicles on the left side. Left-sided hearing loss was documented by brainstem evoked response audiometry (ERA) and brainstem auditory evoked potential (AEP) measurements. The left ear demonstrated marked prolongation of latency-intensity measurements on ERA testing and wave V latency on AEP. Specific testing for apparent threshold was not performed. Ziehl-Nielsen stains of the ear drainage and gastric aspirates were negative. Cultures of the ear drainage and biopsy material were subsequently positive for *Mycobacterium tuberculosis* after eight weeks incubation.

Therapy was begun with isoniazid 10 mg/kg/day and rifampin 10 mg/kg/day, but the family was unable to maintain the treatment regimen. Ear drainage and granulation tissue persisted for three months. An elective radical mastoidectomy was performed. The mastoid cavity was filled with pale granulation tissue and loculated areas of pus. Cultures and smears of the mastoid contents were negative, but Langhans giant cells and areas of caseating necrosis were seen microscopically.

Eighteen months postoperatively and after one year of isoniazid and rifampin therapy, the patient's mastoid cavity has remained dry.

Discussion. The morbidity and mortality from tuberculosis has decreased, yet over 28,500 new cases were reported in this country in 1978.[3] In the general population, the case rate of tuberculosis is 13.1 per 100,000, but the incidence is higher among residents of crowded, low-income communities, the east coast, the Mexican border, Appalachia, and among Native Americans.[4]

Tuberculous otitis presents much as any other suppurative ear disease, but quickly develops severe manifestations. "Classic" signs and symptoms were described by Turner and Fraser[5] in 1915 and have been reiterated by other authorities:[6-10] painless aural discharge of insidious onset; early and disproportionately severe hearing loss; profuse pale granulation tissue in the mastoid and external auditory canal; periauricular node enlargement; periauricular sinuses; subperiosteal abscesses; and facial nerve paralysis. Children are more likely than adults to develop facial paralysis or temporal bone destruction.[7]

The diagnosis of tuberculous otitis is made primarily through laboratory testing. In Jeane's and Friedmann's report[11] only four of ten cultures and two of 11 smears were positive, yet all patients had tuberculous granulation tissue histologically. Multiple specimens probably increase the diagnostic yield.

Treatment regimens always include antituberculous chemotherapy. Surgical intervention is controversial since, with proper drug therapy, the ear drainage usually resolves. Birrell[12] eradicated disease in all eight of his patients and effected improvement in three of four facial paralyses with chemotherapy alone. It is generally agreed, that if the patient is compliant with his or her medications, surgery should only be performed if complications intervene.[9]

Long-term followup has shown that patients regain little of the lost hearing. Craig[8] reviewed eight cases that had been followed for at least 11 years. All had significant residual hearing losses, similarly, facial nerve function usually does not return if lost during the suppurative phase, although reports of recovery have been published.[4,9,12]

Tuberculous otomastoiditis is rare. However, its sequelae, including permanent hearing loss and facial paralysis, are significant. Cultures and smears of ear drainage have high false-negative rates, and the clinician must be alert to the possibility of the disease in high-risk populations even in the face of negative test results.

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Reflex sympathetic dystrophy syndrome: Importance of early diagnosis and appropriate management

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ABSTRACT. *Reflex sympathetic dystrophy syndrome (RSDS) is a well-recognized clinical condition characterized by pain and tenderness, usually in the distal parts of an extremity, vasomotor instability, and trophic skin changes. Although the cause is unclear, autonomic nervous system dysfunction is presumed to be the underlying basis. It is reported following cerebral vascular accidents, myocardial infarctions, cervical trauma, and a variety of soft-tissue injuries. Scintigraphy is the most sensitive indicator of the presence of the syndrome, characterized by increased periarticular radionuclide activity. A wide array of treatment modalities has been suggested, but sympathetic blockade or systemic corticosteroid therapy has been reported to be the most successful when employed early. This paper describes a patient with a cerebral vascular accident in whom RSDS developed rather abruptly. Early and prompt diagnosis was made using roentgenograms and scintiscans. The patient responded dramatically to systemic corticosteroid therapy after sympathetic blockade failed. Scintiscans following treatment with systemic steroids showed improvement. It is suggested that when RSDS is suspected, scintiscans be obtained and systemic steroids be used promptly to prevent sequelae of the syndrome.*

Key words: Sympathetic dystrophy; Scintigraphy; Sympathetic blocks; Corticosteroids; Physical therapy

REFLEX SYMPATHETIC dystrophy syndrome (RSDS), is a well-documented clinical entity which has been given numerous titles including causalgia, Sudeck's atrophy, shoulder-hand syndrome, acute atrophy of the bone, posttraumatic osteoporosis, reflex neurovascular dystrophy, and the like.[1] It is characterized by the following: (1) pain and tenderness in the extremity; (2) pitting or nonpitting edema of the extremity; (3) trophic changes of the skin including atrophy, hair loss, and nail changes; (4) vasomotor instability varying from Raynaud's-type phenomona to warmth, erythema, and hyperhydrosis; and (5) pain and limited range of motion of involved joints.[1-4]

The radiologic features characteristically include juxta-articular osteopenia late in the course of RSDS.[1,5,6] Scintilation scans show an increase uptake of isotope in periarticular tissues, usually early in the course of the disease. Kozin et al[2] report that scintiscans with technetium have been found to be more sensitive than roentgenograms, with more specificity in the diagnosis of RSDS.

RSDS has been associated with trauma.[1,3,7] It has been reported following cervical spine syndrome, spinal cord injury, cerebral vascular accidents with hemiplegia, Herpes zoster, and the like. In approximately one-third of the cases no definitive precipitating event can be identified.[1]

There is disagreement regarding the underlying cause of RSDS. The pathogenesis of RSDS in any given patient may be related to both peripheral and centrally mediated factors.[3,4] The peripheral theory postulates development of artificial synapses between sympathetic efferents and pain carrying afferent fibers leading to cross-firing. Central theory includes overactivation of posterior horn neurons which facilitates activity of internuncial pool and also involves hypothalamus, limbic system, and the like.[4] The results of the overactive sympathetic system are chronic ischemia, vasomotor instability, and dystrophic changes.

Similarly, there is disagreement in regard to the most appropriate treatment for RSDS. The consensus is that early treatment will achieve the best results, and prevention of RSDS is essential.[1,3,8] Schutzer and Gossling[3] recently reviewed the treatment of RSDS. The most frequently used treatment modalities have included physical therapy approaches, sympathetic interruption, and use of corticosteroids.

Case report. A 55-year-old, right-handed female had three episodes of transient ischemic attacks. Evaluations revealed a subclavian steal syndrome with significant narrowing of the subclavian artery, stenosis of the left carotid artery, and some plaque formation. On June 5,

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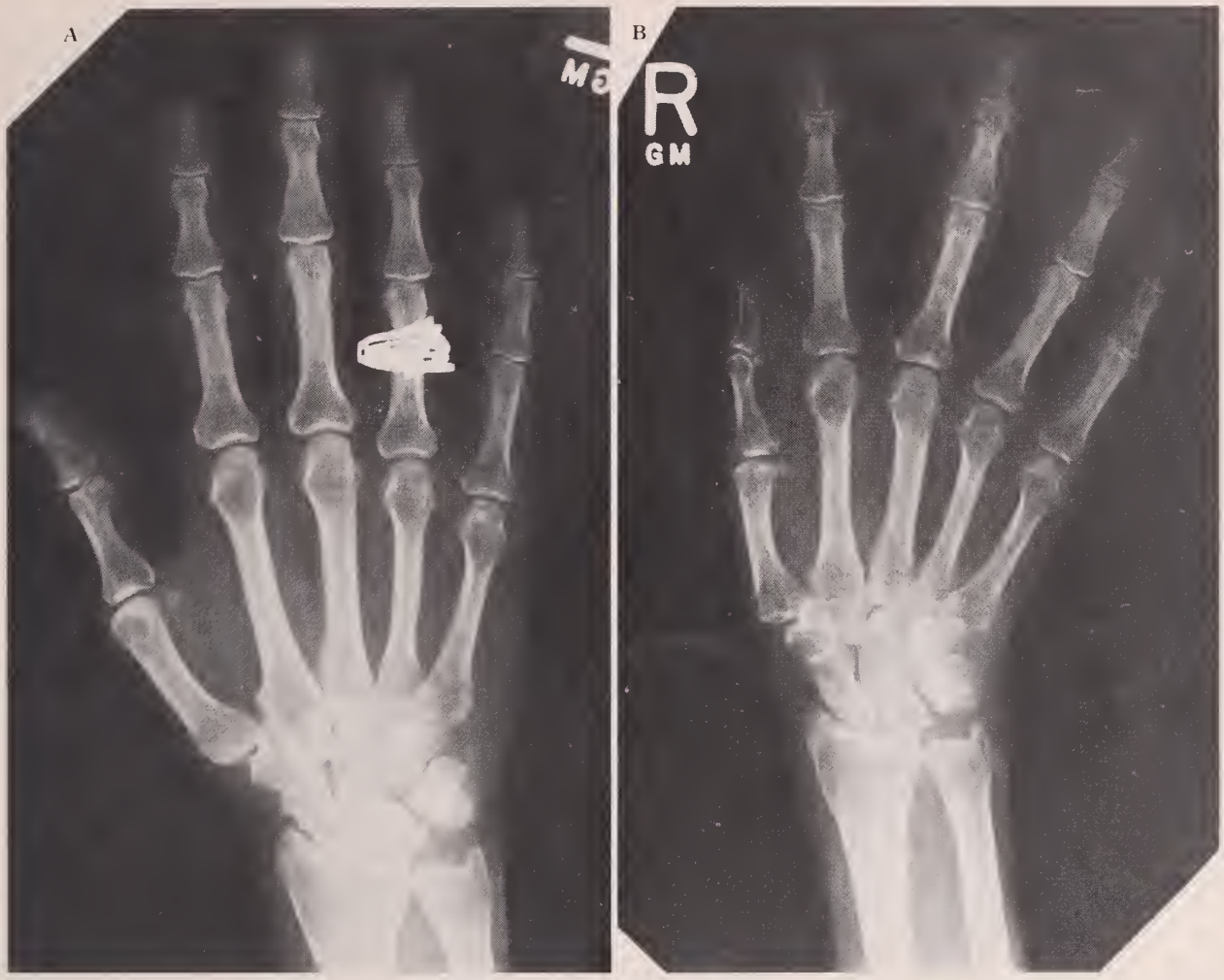

Figure 1 (A) and (B)—*X-ray films of bilateral wrists dated August 15, 1984. The left (A) is normal. The right (B) demonstrates areas of slight demineralization, particularly in the periarticular areas throughout the hand. The distribution and prominence of lucent areas are suggestive of reflex sympathetic dystrophy syndrome.*

1984 she underwent left carotid endarterectomy. Postoperatively she was noted to have a right hemiparesis, and a computerized tomographic (CT) scan revealed an infarction in the left cerebral cortex. Her major deficits were weakness in the right upper extremity and aphasia.

The language deficits resolved over a period of a few weeks. Speech pathology evaluation did not reveal any residual deficits after one month. Her right upper extremity revealed flaccid paresis when examined on June 14, 1984. She was ambulatory with no hypertonus or upper motor neuron signs in the right lower extremity. Sensory examination of right upper and lower extremities were normal.

On July 23, 1984 she presented with complaints of right upper extremity pain, mainly in the shoulder. Range of motion of the right shoulder, which was normal in the examination of June 14, was found to be significantly restricted allowing 90° forward flexion, 60° of abduction, 15° of external rotation, and 10° of internal rotation. There was mild tenderness over the right shoulder.

The right wrist revealed mild puffiness, especially on the dorsal aspect, with nonpitting edema. There was no discoloration and the wrist felt warm, without tenderness. A diagnosis of periarthritis of the shoulder was made and the patient was started on sulindac (Clinoril®) 150 mg two times a day. Physical therapy, consisting of ultrasound to the right shoulder followed by passive exercises with stretch and active exercises, was also prescribed.

By August 6, 1984 there had been no improvement. In the meantime she developed pain in her right hand and had restricted wrist range of motion allowing only 35° of flexion and 20° of extension. Tenderness of the

Figure 2—*Technetium scintiscan taken on August 15, 1984. Static images demonstrate increase in uptake in the wrist and hand suggestive of reflex sympathetic dystrophy syndrome.*

Figure 3—*Followup technetium scan of October 16, 1984. Static scan continues to show slight abnormal uptake in the bones of the right hand and wrist but are less than when compared to August 15, 1984.*

right wrist was noted and the hand was warm to palpation compared to the other hand.

X-ray films of the right shoulder were obtained which revealed bone reabsorption in the humerus with a "salt and pepper" appearance in the cortex. X-ray studies of both wrists revealed asymmetry. The left hand was normal. The right hand revealed areas of slight demineralization particularly in the periarticular areas throughout the hand (Figs 1A and 1B).

A bone scan obtained on August 15, 1984 was done with technetium^{99m} MDP. Static images demonstrated slight increase in uptake in the shoulder girdle, humerus, wrist, and hand. Findings indicated an increased uptake in the right wrist, compatible with reflex sympathetic dystrophy syndrome (Fig 2).

The patient was treated with three stellate ganglion blocks. The first block provided some relief of the pain in the right upper extremity but the two subsequent blocks produced no relief.

On examination of August 13, 1984 she seemed to be extremely anxious, was in significant pain, and was unable to use the arm. Restriction of the shoulder and wrist continued to be present, and all movements were very painful.

Following a rheumatological consultation she was started on 60 mg of prednisone a day in divided doses for one week, then the dosage was tapered over the next two weeks.

Within a period of three to four days following the initiation of steroid therapy she began noticing improvement. The pain in the right shoulder subsided and the pain in the right wrist had subsided by one week. Range of motion also revealed improvement. When seen on September 10, 1984 her shoulder range of motion had increased to 165° forward flexion, 160° abduction, 65° of external rotation, and 20° of internal rotation, all without pain. This was only a few degrees limitation compared to the other side. The right wrist had normal range of motion without any pain. She also revealed dramatic functional improvements. She was able to dress herself and was able to use her hand in functional activities, such as tying shoelaces.

A followup scintiscan was obtained on October 16, 1984. The flow study had reverted to normal on the right, but static studies revealed increase uptake of isotope in the right hand and wrist. However, this was a sig-

nificant improvement over the scan done on September 15, 1984 (Fig 3).

The patient has been seen since then; and as of December 1984, she has had no recurrence of the problem. There has been marked improvement in the right upper extremity functioning, and except for some mild problems in manipulating fine objects, she is totally independent in the use of the right upper extremity. No pain or limitation of motion of the affected extremity is noted.

Discussion. Reflex sympathetic dystrophy syndrome (RSDS) presents with the constellation of symptoms consisting of pain and tenderness in a limb, associated with signs or symptoms of vasomotor instability, trophic changes, and swelling.[2,3,5] Schutzer and Gossling[3] have recently reviewed the presentation of RSDS and discussed the underlying pathophysiology and the treatment approaches.[3] The pathogenesis of RSDS is variable and unclear. It is related to both peripheral and centrally mediated effects.

The diagnosis of RSDS in its earliest stages is at times very difficult. Uematsu[4] discussed the lack of reliable methods to objectively evaluate the condition prior to the development of typical trophic changes. He proposes the temperature asymmetry noted by noninvasive telethermography as helpful in early diagnosis of sympathetic dysfunction before trophic or myofascial changes occur.[4]

Kozin et al[2] emphasize the role of scintigraphic studies as a very sensitive and specific diagnostic tool in detecting early reflex sympathetic dystrophy syndrome. Scintiscans proved to be far more specific than roentgenography with no sacrifice in sensitivity. They also note that scintigraphs appear to be useful as a guide to therapy and noted that 90% of the patients with positive scintigraphs experienced a good to excellent response to corticosteroid therapy compared to 34% of the patients with negative scintigraphs.[2] This suggested that scintigraphy may be used as both a diagnostic aid and a predictor of therapeutic response. In our patient symptoms developed abruptly, initial scintigraphy was positive, and the patient's condition responded rather dramatically to steroids. The followup scan paralleled the clinical improvement. This has been observed by Kozin et al[2] who noted that scintigraphs, which were positive initially, were normal following corticosteroid therapy, suggesting that scintigraphy may demonstrate an active, potentially reversible process.

Sympathetic blockade, using stellate ganglion blocks or local guanethidine blocks, has been used in the treatment of RSDS.[8,9] Goodman[10] used ultrasound over the stellate ganglion followed by concomitant therapy with physical medicine procedures in the treatment of shoulder-hand syndrome.[10] In this study six of the seven patients experienced marked to complete relief of pain, decreased edema, and return of function.

The rationale for using sympathetic blockade in patients with RSDS is interruption of abnormal reflex mediated by the autonomic nervous system. Blockade can be achieved by regional sympathetic block or surgical sympathectomy. Alternatively, intravenous infusion of reserpine or guanethidine, agents that effectively produce a transient chemical sympathectomy, also has been used.[3,6,9] The use of regional sympathetic blockade in a patient who has not responded to physical therapy serves both diagnostic and therapeutic functions. Patients who do not experience any pain relief from a technically successful block should be suspected of having a problem other than RSDS.[3] Although in early stages, a prolonged curative effect is reported from a single stellate or lumbar sympathetic block, multiple blocks are often required for pain control. The most commonly accepted practice is to limit the number of blocks to a maximum of three or four. If a patient demonstrates good clinical response but requires more than four blocks, surgical sympathectomy should be considered.[3,11]

Kleinert et al[12] report 80% of their patients who were resistant to other medical management and physical therapy experienced pain relief from one or more stellate ganglion blocks. Of these, 81% had required no further treatment for one to five years of followup. Nineteen percent (19%) experienced a temporary response but ultimately required surgical sympathectomy. Only 17% of the patients in this group were not permanently improved. Lankford and Thompson[11] also report favorable results with sympathetic blockade. They found that 89% of their patients with causalgia and 80% with other dystrophic variants reported complete long-term palliation. The technique of intravenous infusion of guanethidine, described by Hannington-Kiff[9] in 1974, is based upon the principle that guanethidine functions as a false transmitter, being actively taken up by the sympathetic nerve endings and displaces norepinephrine from its storage sites. Glynn et al[6] demonstrated a significant pain reduction following blocks with intravenous guanethidine compared with physiological saline. However, several patients who were treated with intravenous saline also experienced amelioration of pain, suggesting a strong placebo effect.

Kozin et al[2] report 63% of the patients in a study had a good to excellent response to systemic corticosteroid therapy, and this figure was increased to 82% and 63% in subsets with definite and probable RSDS respectively. Five patients who were given stellate ganglion blockade after corticosteroid therapy showed no improvement in this study. None of the 20 patients who received stellate ganglion blocks in this study had improvement.

The mechanism of action of corticosteroids in treatment of RSDS is still not clear. The potent anti-inflammatory properties of prednisone may account for the therapeutic effect. It is also hypothesized that corticosteroids, by their destablizing effects on basement membranes, can reduce capillary permeability and therefore decrease the plasma extravasation that is commonly associated with the early stage of RSDS.[2,3]

The experience of our patient supports the efficacy of corticosteroid therapy in RSDS. Our patient, within a short period of onset of symptoms, revealed the radiologic diagnostic criteria of juxta-articular osteopenia. In addition, scintigraphy with technetium was definitely positive and valuable in diagnosis. This patient responded rather dramatically to corticosteroid therapy.

Summary. We present a patient who, following a cerebral vascular accident, developed right hemiparesis. Within a short period she developed features of reflex sympathetic dystrophy syndrome. Reports in the literature on reflex sympathetic dystrophy syndrome (RSDS) emphasize early diagnosis. Early diagnosis was made both clinically and using scintigraphy. A series of three stellate ganglion blocks did not provide relief. Oral corticosteroid therapy offered excellent and dramatic improvement, both noted clinically and by scintigraphy.

We suggest that in patients undergoing rehabilitation, symptoms of limb pain should be carefully evaluated for early RSDS. Appropriate diagnostic tests, especially scintigraphy should be considered, and treatment programs initiated early to prevent the disabling sequelae of reflex sympathetic dystrophy syndrome.

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ABSTRACT

Microscopically controlled surgery in the treatment of carcinoma of the penis

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Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1986 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455	$375	Normal County Dues
Resident	45.50	45	Varies
Military Service	-0-	250 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	227.50	375*	Normal County Dues
Over Age 70	227.50	375*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	20	Varies
Sophomore and Succeeding Medical Student Years	10	20	Varies
Postgraduate—One	10	45	Varies

*Physicians in the following categories may be eligible for exemption or reduction from paying AMA dues: (1) Financial hardship and/or disability, (2) Over 70 years of age or older *and* fully retired.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

14 MONTHS FOR THE PRICE OF 12!

Membership policy allows physicians to join their county and state societies and the AMA, or just their county and state societies. Physicians are encouraged to join organized medicine now. Regular membership dues for 1986 are: $455 for SMS, $375 for AMA, and county society dues vary. However, physicians who join now will not pay any dues for the balance of 1985. That's 14 months for the price of 12! Membership applications may be obtained by contacting the secretary of your county medical society or by calling the Membership and Communications Division at the State Medical Society offices in Madison at 608/257-6781 or toll free: 800/362-9080.■

Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1985 Membership Directory as published in the July 1985 issue of the *Wisconsin Medical Journal*. Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership records. County transfers will be included when processing has been completed by the Membership Department.

Changes in practice specialties (as used by the AMA) and changes in **Board-certified specialties** as listed by the American Board of Medical Specialties.

(changes only with member's name; practice specialties appear before the slash (/) and Board-certified specialties appear after the slash.)

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Route 2, Box 17
Rice Lake WI 54868

BROWN

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Matthias Fuchs MD

ORS / ORS
Richard D Horak MD

ORS / ORS
Wayne S Mohr MD

DANE

PD
John M Bohn MD

P
Barbara L Calhoun MD

IM PUD / IM PUD
Geoffrey R Priest MD

R Browning Windsor Jr, MD
305 N 95th St
Milwaukee WI 53226

DODGE

DR / R
Douglas E Bricker MD
116 Monroe St
Beaver Dam WI 53916

PTH FP / PTH FP
Victor W Caceres MD

FP / FP
Charles W Frinak MD
1200 North Center St
Beaver Dam WI 53916

DOUGLAS

GS FP / FP
Dwain L Stone MD
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Superior WI 54880

EAU CLAIRE/ DUNN/ PEPIN

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826 S Hastings Way
Eau Claire WI 54701

GRANT

FP
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Rte 1, Box 151
Viroqua WI 54665

IM CD / IM
Maruthi M P Kantameni MD
207 East Skelly
Cuba City WI 53807

JEFFERSON

GP OBG GS
E Allen Miller MD

LA CROSSE

OBG / OBG
Martha H Blaisdell MD
815 South 10th St
La Crosse WI 54601

OTO HNS
Scott B Blanke MD
815 South 10th St
La Crosse WI 54601

PD GS
Bethann Bonner MD
1900 South 7th St
La Crosse WI 54601

FP
Scott D Brunk MD
2022 Adams St
La Crosse WI 54601

IM
Roland B Christian MD
2213-B S 7th St
La Crosse WI 54601

ORS
Richard P Driessnack MD
212 South 11th St
La Crosse WI 54601

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Robert W Ellwein MD
700 West Ave South
La Crosse WI 54602

FP / FP
Brett A Feighner MD
700 West Ave South
La Crosse WI 54601

OBG / OBG
Jerome H Gundersen MD
1836 South Ave
La Crosse WI 54601

FP
Theodor Habel MD
502 Washington
Westby WI 54667

EM
Milton R Mc Millen MD
1252 Cliffwood Lane
La Crosse WI 54601

FP
David A Onsrud DO
815 South 10 St
La Crosse WI 54601

LINCOLN

IM
David C Yang MD
716 East 2nd St
Merrill WI 54452

MANITOWOC

GS TS CDS / GS
Terry L Gueldner MD

MILWAUKEE

Manuel M Aquino MD
4893 N Green Bay Rd
Milwaukee WI 53209

PS HS / PS
Dilip K Das MD
3124 South 27th St
Milwaukee WI 53215

ON HEM IM / IM HEM
Nicholas F Geimer MD

PUD IM / PUD IM
Paul M Guzzetta MD

Stephen W Hargarten MD
PO Box 503
Milwaukee WI 53201

AN / AN
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7405 N Braeburn Lane
Milwaukee WI 53209

GS CDS OS / GS
Bahram Namdari MD

HS / ORS
Mysore S Shivaram MD

FP / FP
Steven R Sirus MD

P / P
K Kwang Soo MD

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Alfred J Tector Jr MD

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Marta C Muller MD
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Milwaukee WI 53202

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ORS PYM P / ORS
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Doctors! Watch your mail for the 1986 membership dues statement scheduled to arrive in mid-November. See page 31 of this issue for further details.

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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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In Hypertension*... When You Need to Conserve K^+

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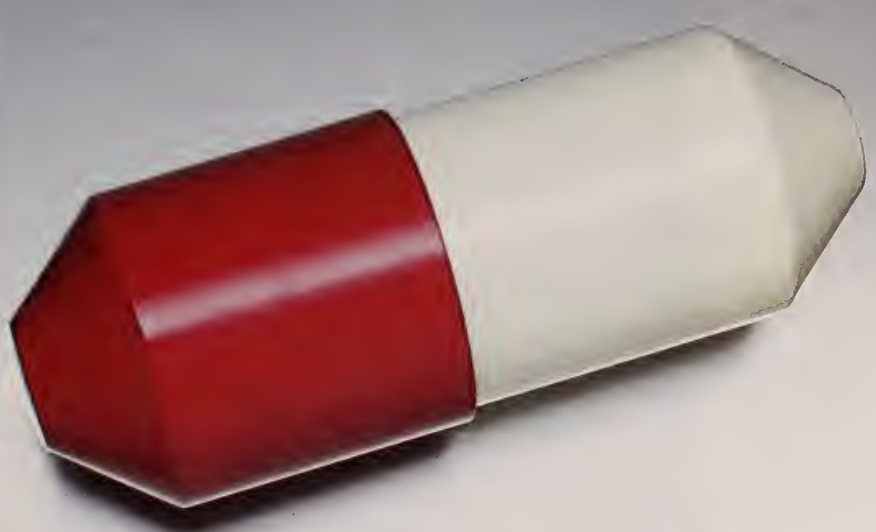
Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



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To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

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With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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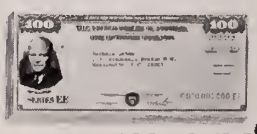

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J-5491 June 1985

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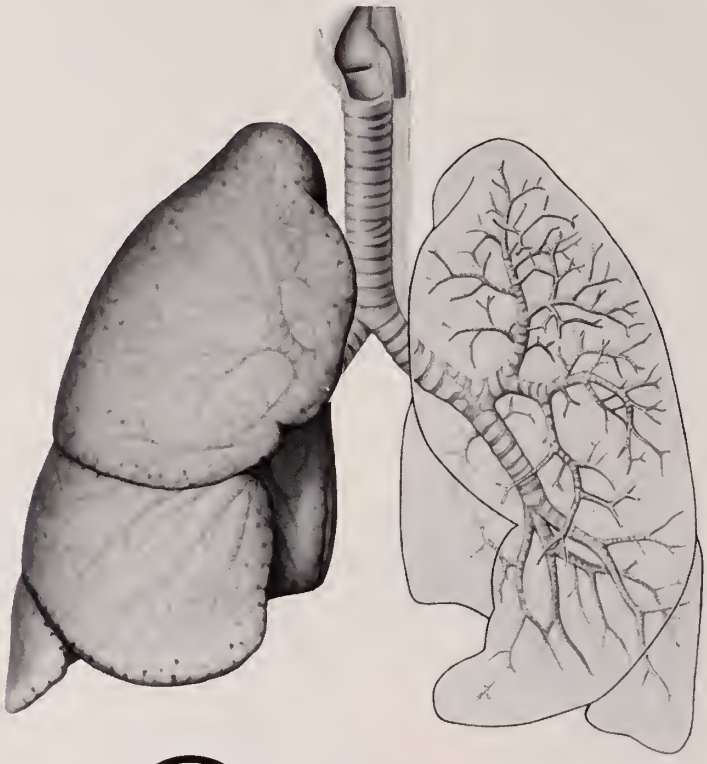

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H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
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Brief Summary Consult the package literature for prescribing information

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbiliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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42% to 46% decrease reported in multicenter study.[1]

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In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

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(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

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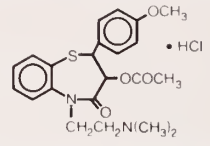
cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-8enzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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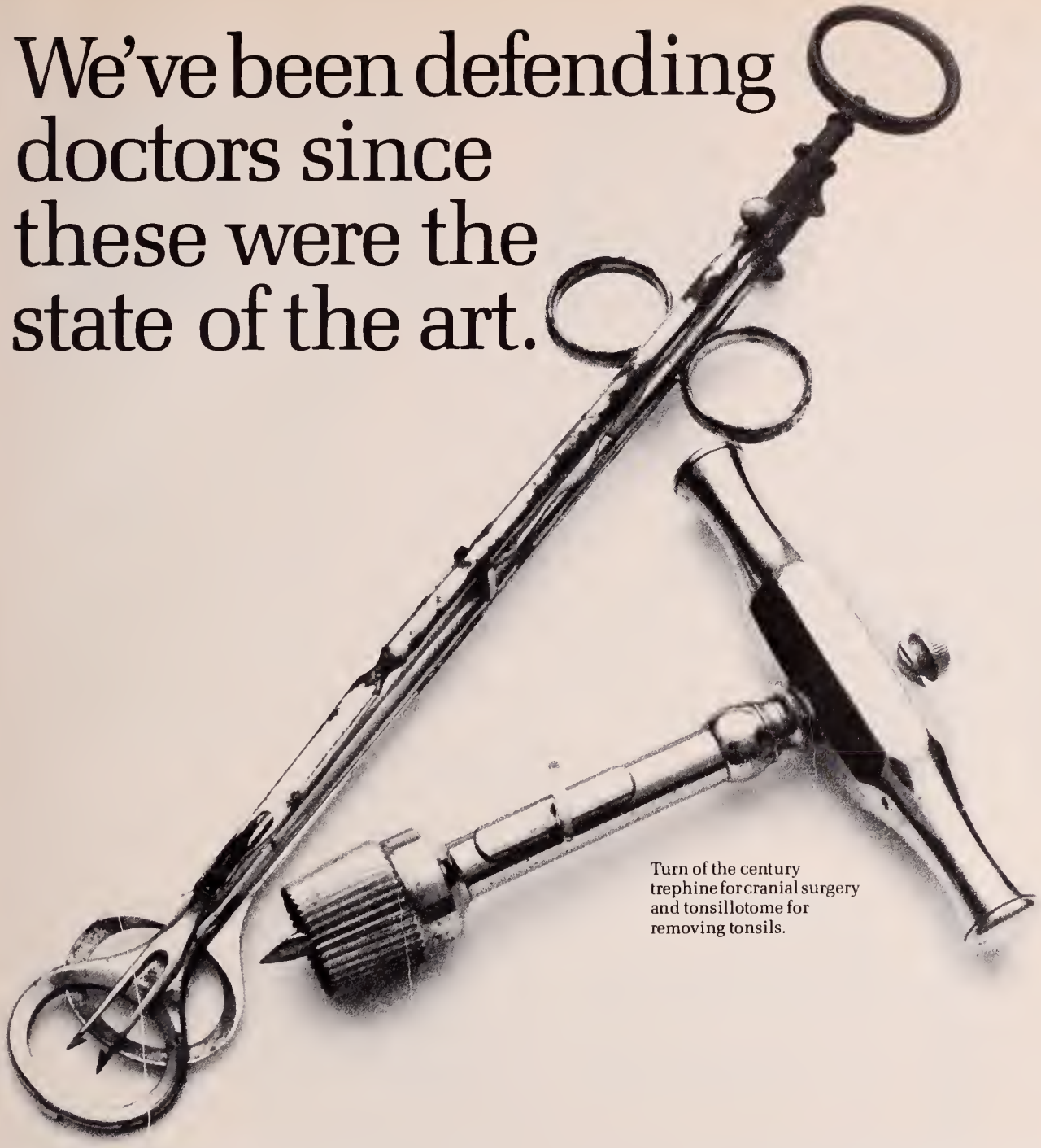

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Hearing held on PT practice without referral

The Senate Agriculture, Health and Human Services Committee in September held a hearing on a bill which would authorize physical therapists to evaluate and treat patients without referral.

Senate Bill 233, introduced by that Committee, removes from the law the requirement that physical therapists may practice only upon the written referral of a physician, dentist, or podiatrist. The bill is primarily promoted by physical therapists who are practicing independently from medical clinic settings.

In the last legislative session this same group of physical therapists tried to pass legislation to bar physician service corporations from employing physical therapists. When that was rejected in Committee, the practice without referral bill was introduced.

Michael C Reineck, MD, a West Bend orthopedic surgeon, testified on the Medical Society's behalf against the bill. He reminded the Committee that physical therapy is just one form of therapy, and one form of therapy is not enough for many patients.

While complimentary to the PT profession, Doctor Reineck noted their training has not prepared them to take on the responsibility as managers in evaluation and treatment.

A few weeks prior to this hearing a public hearing was held on a companion bill, Assembly Bill 256. Tai J Park, MD, Neenah; Neal Taylor, MD, La Crosse; and Daniel Halpern, MD, Madison, testified on behalf of the Medical Society in opposition to AB 256.

Physician contacts are needed to block Committee approval of both SB 233 and AB 256. Either bill would allow physical therapists to receive patients without confirmed diagnoses.

The SMS Physicians Alliance Division and its field consultants can provide a list of the members of the Senate Agriculture, Health and Human Services Committee and the Assembly Health Committee. See contact information elsewhere in this section.■

CES Foundation of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of August 1985.

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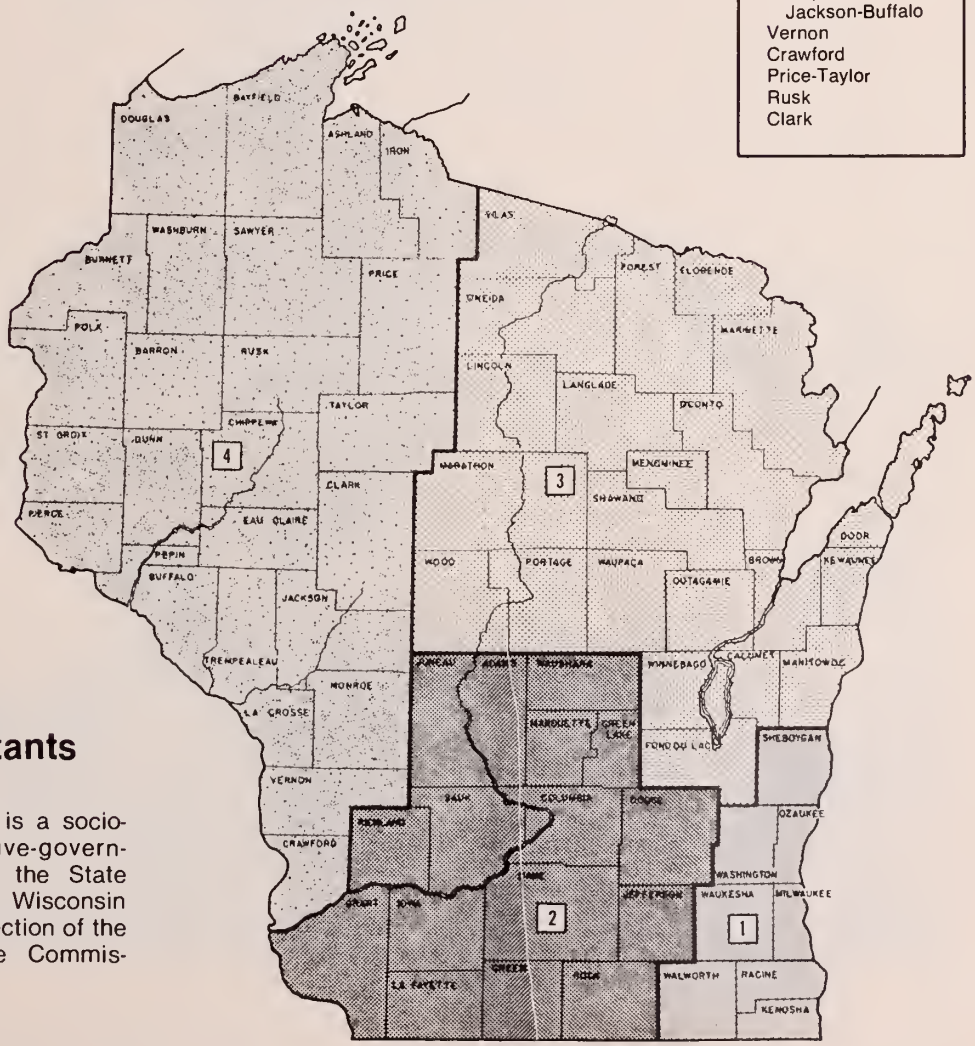

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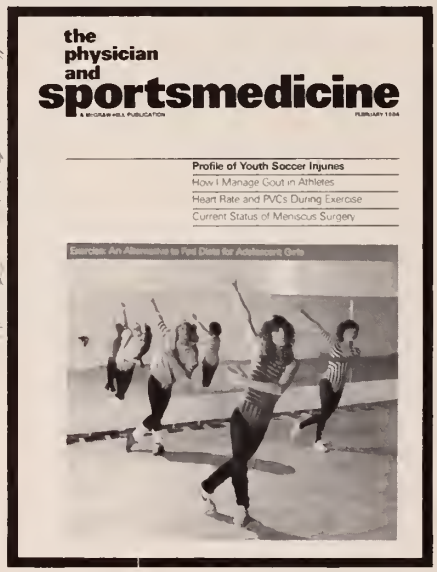

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SMS physicians testify for additional mental commitment standard

The Assembly Judiciary Commitee held a public hearing in mid-September on a State Medical Society-requested bill to create a "fifth standard" for involuntary civil commitment under the Mental Health Act. Assembly Bill 311, introduced by Representative John Medinger, (D-La Crosse) would, with existing due process, authorize treatment for individuals who are obviously mentally ill, but due to the mental illness, are not capable of understanding their need for treatment.

Darold A Treffert, MD, a psychiatrist from Fond du Lac and chairman of the SMS Board of Directors, testified on behalf of the Society in support of AB 311. He refuted claims that passage of the bill would be invalidated on constitutional grounds by emphasizing the bill maintained all existing due process. "It is not to make commitment easier, it only allows patients to be treated at the proper time," Doctor Treffert told the Committee.

Pauline M Jackson, MD, a La Crosse psychiatrist who also serves on the SMS Board of Directors and the Mental Health Committee, also testified on behalf of the Medical Society. She likened the mental health treatment system of the past and present as a pendulum swing that was too short on due process and freedom from unwarranted restraint at one extreme to one that is too short on a sick person's right to treatment on the other. "AB 311 would bring the pendulum back toward the center" Doctor Jackson said.

Critics of the bill say that a court challenge is a virtual certainty should it become law. The Wisconsin Civil Liberties Union indicated that it would assist in underwriting the case.

The constitutional issue arises based on a landmark 1972 Wisconsin case in *Lessard vs Schmidt*. The court's interpretation of Wisconsin's 1972 vague and loosely-defined mental commitment statute was construed as implying a standard of dangerousness. Some now believe that commitment standards may only be based on dangerousness.

The Medical Society's strong opinion is that the court did not preempt a more carefully formulated need-for-treatment standard.

The Judiciary Committee also heard testimony on a Joint Resolution calling for a study to recommend changes to the mental health treatment system. At the time of this hearing it appeared as if the Committee chairman would not move AB 311 but instead would go with the study proposal.

Physicians are urged to contact their legislators in support of AB 311 and encourage them to do all they can to move the bill from Committee.■

Bill waiving interest on overdue insurance claims rejected

The Assembly Financial Institutions and Insurance Committee last month voted to kill a bill which waived insurance companies' obligations to pay interest on overdue insurance claims if the amount of interest due was less than $5.

Assembly Bill 246, introduced by Rep John Robinson (D-Wausau), amended an existing law which requires insurers to pay an annual rate of 12% simple interest unless claims are paid within 30 days of receipt. The existing law is applicable to health insurance reimbursement paid directly to physicians, hospitals, and clinics.

The bill was promoted mainly by Blue Cross and WPS to allegedly end the practice of issuing miniscule separate interest checks.

Many legislators received communications from constituents complaining about the waste in receiving a separate interest check for as little as one cent.

Suspicions arose at the hearing on AB 246 when it was pointed out that almost every insurance company had the technology in place to add the amount of interest to the claim check. Because the bill also extended the time limit before a claim was overdue from 30 days to 30 *business* days, it was obvious to the Committee that the bill's only aim was for insurers to keep their money longer to increase profit margins.

The Medical Society voiced strong opposition to the bill. Representatives voting to kill the bill were Carpenter, Tesmer, Crawford, Antaramian, Black, Fergus, Huelsman, Ladwig, and Schneiders. Voting in support were Hauke and John Young.■

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

Charles Francis Foley, MD, 91, died May 3, 1985 in Sparta. Born May 14, 1893 in Kingston, Doctor Foley graduated from Marquette University School of Medicine, Milwaukee, in 1916. He served in the United States Navy during World War I. He was a physician at Soldiers Grove, Wilton, and at the Veterans Administration Hospital, Tomah, before retiring. Surviving are his widow, Caroline; two sons, Charles, Shell Lake; Gregory, Janesville; and a daughter, Alice Robertson of Chicago, Ill.

Lucy A Vernetti, MD, Phoenix, Ariz, died May 3, 1985 in Phoenix. Born in Italy and raised in Hurley, Wis, Doctor Vernetti graduated from the University of Wisconsin Medical School in Madison. She served her internship in Phoenix and practiced medicine there until 1979. She was preceded in death by her husband, Fred McLellan. Surviving are two brothers, Garfield Vernetti, Shafter, Calif, and Gene Vernetti of Canoga Park, Calif.

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Francis E Gehin, MD, 66, Stevens Point, died July 12, 1985 in Stevens Point. Born Jan 28, 1919 in Belleville, Doctor Gehin graduated from the University of Wisconsin Medical School, Madison, and served his internship in New Orleans, La. Doctor Gehin began his practice in 1947 in Stevens Point and practiced medicine until his retirement in 1984. He was a member of the Portage County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, JoAnne; six sons, Paul, Stevens Point; Bruce, Rudolph; Phillip, Reno, Nev; Gregory, Ottawa, Ill, and Mark and David of Stevens Point.

Raymond J Murphy, MD, 48, Green Bay, died July 17, 1985 in Green Bay. Born Aug 15, 1936 in Appleton, Doctor Murphy graduated from the University of Wisconsin Medical School, Madison, and served his residency at the Medical College of Wisconsin in Milwaukee. Doctor Murphy served in the United States Navy from 1963-65. He was chief of the Department of OB/GYN at St Vincent Hospital and was a past member of the board at Bellin Memorial Hospital in Green Bay. He was a member of the American College of OB/GYN; the Northeastern Wisconsin Perinatal Association; the Wisconsin Society of Obstetrics and Gynecology; the Brown County Medical Society; the State Medical Society of Wisconsin and the American Medical Association. Surviving are his widow, Beverly; two sons, Patrick and Sean, and two daughters, Molly and Kelly, all at home.

Lester E Haushalter, MD, 76, Brookfield, died Aug 8, 1985 in Wauwatosa. Born June 5, 1909 in Milwaukee. Born June 5, 1909 in graduated from Marquette University School of Medicine, Milwaukee, and served his internship at St Joseph's Hospital, Milwaukee. He served in the United States Army Medical Corps during World War II and received a Bronze Star and Purple Heart. Doctor Haushalter practiced medicine in the Milwaukee area for 43 years before retiring in 1977. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Marilyn; two daughters, Mary Eldridge, Simsbury, Conn; Judith Melino, Rochester, New York; three sons, Jerry, Los Angeles, Calif; Navy Capt William, San Pedro, Calif; and Dr Robert of Elm Grove. Other survivors include his stepchildren, Jaclyn Lemke, Stuart, VA; James Lees, Brookfield; Jill Kumlien, Brookfield; and Mary Lynn Allen of Wautoma.

Ruth E Church, MD, 80, Whitewater, died Aug 11, 1985 in Waukesha. Born Aug 8, 1905 in Walworth, Doctor Church graduated from the University of Wisconsin Medical School, Madison, in 1937. She was a member of the Wisconsin Department of Public Health from 1937-1939; Iowa Department of Public Health from 1939-1945; and was director of the Illinois Department of Public Health from 1945-1951. Doctor Church served in the United States Army Medical Corps from 1953-1955 during the Korean Conflict. She was director of the Waukesha County Public Health Department from 1961-1967. She was a member of the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.■

Robert Jacobson, MD, has joined the Iron County Clinic, Hurley, in association with Bruce Gordon, MD. Doctor Jacobson graduated from the University of Wisconsin Medical School, Madison and completed his family practice residency at the University of Colorado Health Science Center, Pueblo, Colo.

Mark Villwock, MD, recently became associated with the Deckner Clinic in Green Bay. Doctor Villwock graduated from the Medical College of Wisconsin, Milwaukee, and completed his family practice residency at Good Samaritan Medical Center, Milwaukee.

Harry Bayron, MD, Marshfield, has joined the medical staff of the Marshfield Clinic. Doctor Bayron graduated from the University of Puerto Rico School of Medicine. His residency was completed at the University of Connecticut School of Medicine followed by a fellowship at the University of Miami/Jackson Memorial Hospital Medical Center.

Young K Lee, MD, La Crosse, has been named as recipient of the Distinguished Teaching Award of the University of Wisconsin-Madison Medical Alumni Association. Doctor Lee is a graduate from Seoul National University School of Medicine in Korea and served his residency at the University of Wisconsin-Madison. A member of the medical staff of the Gundersen Clinic Ltd since 1974, Doctor Lee is president-elect of the Wisconsin Society of Anesthesiologists.

V Jill K Kempthorne, MD, Madison, has joined the Department of Pediatrics at the Jackson Clinic's East Towne office. Doctor Kempthorne graduated from the University of Washington School of Medicine in Seattle. She completed her residency at the Children's Orthopedic Hospital and Medical Center, Seattle. Prior to joining the Jackson Clinic, Doctor Kempthorne held positions as house physician, Department of Pediatrics, Carney Hospital, Boston; pediatrician and medical director, Codman Square Health Center, Dorchester, Mass; and as clinical instructor at the Tufts University School of Medicine.

Graham D Avery, MD, has become a member of the medical staff of the Marshfield Clinic. Doctor Avery graduated from the University of Texas Medical Branch in Galveston. Following a year of research at the University of Texas Health Science Center in Houston, Doctor Avery also completed his residency at the Center. A fellowship was completed at Washington University-Barnes Hospital in St Louis.

George H Handy, MD,* Madison, Chief Medical Consultant of the Bureau of Social Security Disability Insurance of the Department of Health and Social Services, retired this month. Doctor Handy graduated from Rush Medical College, Chicago, and served his internship at King County Hospital System in Seattle. Licensed to practice medicine in Wisconsin in 1947, he was in private practice in Wisconsin until 1964. In 1965 he received his master's degree in Public Health at the University of Minnesota and in 1967 joined the State Division of Health and served as State Health Officer from 1971-1976. In 1976 he became Medical Director of the CUNA Mutual Insurance Group in Madison, and in 1982 became the Chief Medical Consultant for the BSSDI.

Theodore A Praxel, MD,* Wisconsin Rapids, has become a member of the medical staff of Doctor's Clinic. A native of Milwaukee, Doctor Praxel graduated from the Medical College of Wisconsin and completed his residency at St Joseph's Hospital and the Marshfield Clinic in Marshfield.

Arnold J Aguilera, MD, has joined the medical staff of the Gundersen Clinic, Ltd in La Crosse. Doctor Aguilera graduated from the University of Iowa College of Medicine and completed his internship at the University of Rochester School of Medicine and Dentistry, Rochester, NY. His residency was completed at the University of New Mexico School of Medicine in Albuquerque. He most recently completed a fellowship at the University of Colorado Health Sciences Center in Denver.

Doctor Handy

Doctor Thorpe

Robert F Thorpe, MD,* Manitowoc, who was the original physician when the Manitowoc Clinic opened in 1950, has retired from his medical practice. Doctor Thorpe graduated from the University of Illinois in Champaign, Ill, and served his internship and residency at Cook County Hospital in Chicago. Doctor Thorpe was a member of the Memorial Hospital medical staff and had served as president of the medical staff in 1966 and 1968.

John J Maher, MD, Beloit, recently joined the medical staff of the Beloit Memorial Hospital in the Emergency Department. Doctor Maher graduated from Eastern Virginia Medical School and completed his residency at Akron General Medical Center, Ohio.

Mark W Francis, MD, Beloit, has become a member of the medical staff of the Beloit Memorial Hospital in the Emergency Department. Doctor Francis graduated from the University of Rochester School of Medicine and Dentistry, New York, and completed his residency at the Medical College of Pennsylvania.

Kevin G Derus, MD, Beloit, a graduate from the Medical College of Wisconsin, Milwaukee, has joined the medical staff of the Beloit Memorial Hospital in the Emergency Department. Doctor Derus completed his residency at the Akron General Medical Center in Ohio.

Doctor Maher

Doctor Francis

Doctor Derus

Annette Z Stormont, MD, Monroe, recently became associated with The Monroe Clinic. Doctor Stormont graduated from the Medical College of Wisconsin in Milwaukee, and served her internship at St Joseph's Hospital in Milwaukee. Her residency was completed at the Mayo Graduate School of Medicine in Rochester, Minn, where she also served as chief resident in the Department of Ophthalmology. Her husband, Daniel M Stormont, MD recently became associated with the Department of Orthopedic Surgery at The Monroe Clinic.

William R O'Shields, MD, Chippewa Falls, recently joined the medical staff of St Joseph's Hospital in Chippewa Falls. Doctor O'Shields graduated from the University of Minnesota School of Medicine and served his internship at the State University of New York-Stony Brook, and completed his residency at St Paul Ramsey Medical Center in Minnesota.

Charles J Gehring, MD, Sheboygan, recently became a member of the Department of Anesthesiology at Sheboygan Memorial Hospital. Doctor Gehring graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency at the University of Wisconsin Hospital and Clinics in Madison.

Alayne J Van Erem, MD, has joined the medical staff of the Marshfield Clinic. Doctor Van Erem graduated from the University of North Dakota in Grand Forks and served an internship at Milwaukee Children's Hospital. Her residency was completed at Georgetown University in Washington, DC. Doctor Van Erem was in private practice in Warrentown, VA; was on the medical staff at Kaiser Permanente in Walnut Creek, Calif, and was in group practice in Pleasant Hill, Calif, before coming to Marshfield.

Albert J Motzel Jr, MD, Waukesha, closed his surgical practice on July 31 after 27 years of practice in the Waukesha area. On August 1 he assumed a new position as vice president for medical affairs with the Waukesha Memorial Hospital. In announcing the change Doctor Motzel noted that his increasing involvement with medical staff activities, quality assurance, continuing medical education and planning at the hospital, and the changes occurring in health care today were becoming so overwhelming that he could no longer continue as an individual practitioner. However, he hopes that in his new role he can contribute significantly to the advancement of high quality, effective care in the Waukesha community.

Bradley C Fry, MD, Sheboygan, has joined the Department of Anesthesiology at Sheboygan Memorial Hospital. Doctor Fry graduated from the University of Wisconsin Medical School, Madison, and completed his residency at University Hospital in Cleveland.

Gary F Steele, MD, Brownsville, has joined the medical staff at the Brownsville Family Center. He is a graduate of the West Virginia School of Medicine and served his internship at the Charleston Area Medical Center in West Virginia. After completing a tour of duty with the United States Navy, Doctor Steele completed a family practice residency at the Regional Medical Center in Charleston.

Stephen M Endres, MD, Eau Claire, has joined the medical staff at Eau Claire Anesthesiologists Ltd. Doctor Endres graduated from the University of Minnesota Medical School and completed his residency at the Mayo Clinic in Rochester, Minn.

Douglas Cowgill, MD, Marshfield, recently became associated with the Marshfield Clinic. He graduated from the University of Southern California School of Medicine, Los Angeles, and completed an internship at Los Angeles County-USC Medical Center. Doctor Cowgill practiced medicine with the Indian Health Service in Bethel, Alaska, for four years and then returned to Los Angeles County USC to complete his residency in surgery. He also completed a fellowship at the Baylor School of Medicine, Houston, Texas. Prior to joining the Marshfield Clinic, Doctor Cowgill completed a residency at the University of Colorado Health Sciences Center in Denver.

Donald T Bishop, MD, Beloit, recently became a member of the medical staff of Beloit Clinic, SC. Doctor Bishop graduated from the University of Colorado Medical School and completed his residency at Santa Clara Valley Medical Center in San Jose, Calif. He also completed a fellowship at the University of Wisconsin Hospital and Clinics and currently is a clinical assistant professor at the UW Hospital and Clinics. He previously served as director of the ICU/CCU at the Veterans Administration Medical Center in Boise, Idaho.

John Pirsch, MD, Madison, recently joined the Department of Internal Medicine at the East Towne office of the Jackson Clinic. Doctor Pirsch graduated from the University of Minnesota Medical School, and completed his internship and residency at the University of Wisconsin Hospital and Clinics, Madison. Prior to joining the Clinic, Doctor Pirsch was an admitting officer at the Veterans Administration Hospital, Madison, and was Director of Emergency Rooms in Stoughton and Edgerton.■

1986 ANNUAL MEETING: APRIL 17–19, MILWAUKEE

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PHYSICIANS EXCHANGE

Internal Medicine: BC/BE. Established 50-doctor multispecialty group practice located in the Milwaukee, Wisconsin metropolitan area. Expanding practice needs two internists. Competitive salary and excellent fringe benefits. Address inquiries and CV to Medical Director, PO Box 427, Menomonee Falls, WI 53051. p10-11/85

Primary Care. Seeking primary care physician interested in diagnostic challenges, both inpatient and outpatient, and providing primary care for individuals with mental retardation (all ages). In addition, the health of group home clients from the Eastern half of the US is to be monitored. Bethesda Lutheran Home is located on the banks of the Rock River in South Central Wisconsin. Come join a progressive staff interested in meeting the challenges presented by our clients. Send resume to: John C Heffelfinger, MD, Medical Director, Bethesda Lutheran Home, 700 Hoffman Dr, Watertown, WI 53094. 10/85

Family practice opportunity—very busy five-physician practice being covered by four physicians. Pleasant South Central Wisconsin community of 15,000; close to Milwaukee and Madison. Excellent recreational area. First-year guaranteed salary. Excellent benefits. Contact: C Burchardt, Medical Associates, 1200 N Center, Beaver Dam, WI 53916; ph 414/887-7101. 10tfn/85

General Internist. Board certified/board eligible. Opening established practice with large multispecialty clinic, Madison. Competitive salary, excellent fringe benefits. Send curriculum vitae and references to Dept 568 in care of the Journal. p10-11/85

Rheumatologist. Will complete training in a University rheumatology fellowship 7/86. Interested in a practice opportunity in Wisconsin or elsewhere in Midwest. Please contact Dept 564 in care of the Journal. p10/85

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; e.g., copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 10-12/85;1-3/86

Family Practice. Third family practice physician needed to join multispecialty group of 17 in Hartford, WI. Two branch locations. All facilities modern and well equipped. Guaranteed first year negotiable salary; usual fringe benefits. Contact: Murlin Bernd, Clinic Manager, 1004 E Sumner St, Hartford, WI 53027; ph 414/673-5745. 10-11/85

Pediatrician. BC/BE to join busy four-member Pediatric Department within a 23-member multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 54303; ph 414/494-5611. 10-11/85;1-2/86

Physician interested in purchasing Internal Medicine General Practice in Milwaukee. Please send information including type of practice, total number of patients, and total number of active files. Contact Dept 569 in care of the Journal. 10/85

Appleton, Wisconsin—seeking physician for weekend coverage at family practice clinic affiliated with local hospital. Flexible hours and attractive compensation. Submit resume to Emergency Consultants, Inc, 2240 South Airport Rd, Traverse City, MI 49684; 1-800/253-1795 or in Michigan 1-800/632-3496. p10/85

West Bend, Wisconsin, General Clinic, a (18) physician multispecialty group, is seeking physicians in the specialties of Internal Medicine, Family Practice, OB/GYN, and Pediatrics. First-year salary guaranteed. Corporate membership possible after one year. Excellent fringe benefits. Located in scenic, recreational area with close proximity to Milwaukee. Please contact Hans W Schmelzling, Administrator, General Clinic, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 6tfn/85

Radiologist-Board certified, available for part-time position for clinics in Milwaukee and neighboring counties. Contact Dept 567 in care of the Journal. 10-11/85

Excellent opportunity for a Board certified or eligible internist to practice in conjunction with an 8-member Internal Medicine Department of a 26-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 6tfn/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

OB/GYN: BC/BE to join three OB-GYNs in 31-physician multispecialty group. Beautiful lakefront community of 90,000 located between Milwaukee and Chicago offers a wealth of cultural, educational, and recreational opportunities. Well-equipped clinic and two local hospitals; salary guarantee with incentive bonus; excellent fringe benefits and early partnership. Send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

General and surgical solo practice for sale. Gross in excess of $300,000. Growing desirable midwestern university city with population 25,000. One very well-equipped hospital in county of 60,000 a few blocks away. Owner will remain to introduce. Contact Dept 563 in care of the Journal. 9tfn/85

Orthopedic Surgeon sought by state-of-the-art multispecialty group in Milwaukee, Wisconsin. Board certified/eligible physician to join 3 other orthopedists in the performance of independent orthpedic evaluations for the purpose of determining appropriate treatment or disability. No weekends, no call, no surgery. Competitive salary and fringe benefits. Please submit CV to Dept 566 in care of the Journal. p10-11/85

PHYSICIANS EXCHANGE

continued

Family Practice: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary gaurantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Emergency Physician. Seeking third full-time associate for modern, well-equipped emergency outpatient department. Lower volume ER. Thirty-five miles north of Green Bay. Board eligible, ATLS, ACLS certification desirable. Beautiful rural Wisconsin. Send inquiries with CV to Administrator, Community Memorial Hospital, 855 S Main St, Oconto Falls, WI 54154 or call 414/846-3444. 10-11/85

Internist-Infectious Disease Physician. The Racine Medical Clinic, a progressive cluster corporation of 32 physicians, is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 6tfn/85

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Contact: Ms Debbie Carsky, Director of Recruitment, 312/459-7304 (collect) or write to 15 South McHenry Road, Buffalo Grove, IL 60090. 10/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

Versatile Surgeon wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E Johnson, Ely Medical Center, Ltd, 224 East Chapman Street, Ely, Mn 55731; ph 218/365-3151. 6tfn/85

Internist/Cardiologist for multispecialty group practice in Milwaukee, Wisconsin. Extremely well-equipped modern facility with stress thallium, echo, holter, etc. Applicant should be Board certified/eligible in cardiology but must be willing to do general medicine also. Please forward CV to Dept 565 in care of the Journal. p10/85

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone 608/263-4095 7/85-6/86

Primary care physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to: Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. 9-12/85

We are seeking three (3) Board certified/eligible family practice physicians for a new Ambulatory Care Center in the Milwaukee area; attractive work hours and financial package. Please send CV or call: Ms Debbie Carsky, Director of Recruitment, MESA (Medical Emergency Service Associates), 15 S McHenry Rd, Buffalo Grove, IL 60089; 312/459-7304. 10/85

Ophthalmologist. Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Immediate drawing area 100,000. Located on Lake Michigan with excellent recreational activities. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Pediatrics/Neonatology: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits, and early ownership. Neonatology skills needed for Level II Nursery. Please send curriculum vitae to R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Wisconsin: Pediatrician with subspecialty interest to join multispecialty clinic that includes general pediatricians, pediatric hematologist, oncologist and neonatologist in city of 150,000. Send CV to Dept 561 in care of the Journal. 8tfn/85

PHYSICIANS EXCHANGE

continued

General Internist. Marshfield Clinic, one of the nation's largest multispecialty private groups, is seeking several Board certified/Board eligible General Internal Medicine specialists to join its expanding 16-member section. Internal Medicine Residency Program, University affiliation, Research Foundation, and large regional referral base contributes to a very stimulating environment. Unique big city medicine opportunity in a family-oriented rural setting. Please send curriculum vitae to: John P Folz, Assistant Director, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or call collect at 715/387-5181. 9-11/85

Internist with or without subspecialty interest. Board Certified or eligible, to join six other internists in a well-established, 23-man expanding multispecialty group in prosperous lakeside southeastern Wisconsin city of 36,000. The Internal Medicine Department currently has subspecialties in cardiology, pulmonary medicine, and medical oncology. Liberal fringe benefits. Initial salary plus percentage as associate. Full status in service corporation, with incentive-oriented formula after first year. Contact J F Kuglitsch, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935; ph 414/923-7420 collect. 5tfn/85

Ophthalmologist, subspecialty pediatrics or glaucoma helpful but not required, Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Must be willing to do general ophthalmology. Immediate drawing area 100,000 with unopposed subspecialty referral area much higher. Located on Lake Michigan with excellent recreational activities. Optometric support available. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Family practice physician, internist and OB/GYN physicians needed to join a multispecialty clinic in NE Wisconsin. Excellent starting salary, full benefits, partnership one year, HMO affiliated. Contact Stephen C Caselton, MD, 2152 Riverside Ave, Marinette, Wis 54143; ph 715/732-2211. p8-10/85

MEDICAL FACILITIES

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MISCELLANEOUS

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MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

NOVEMBER 16, 1985: Wisconsin Society of Pathologists, American Club, Kohler. g9-10/85

NOVEMBER 18-21, 1985 (Louisiana): *A Primary Care Update,* the 70th Scientific Assembly of Interstate Postgraduate Medical Association. Accredited by ACCME and eligible for 24 hours of Category 1 and 4 hours of Category 5 credit of the AMA/PRA. Acceptable for 24 prescribed hours credit by American Academy of Family Physicians and 24 hours by the College of Family Physicians of Canada. Info: IPMANA, PO Box 1109, Madison, WI 53701 g9-10/85

DECEMBER 6-7, 1985: *5th Annual Conference on Heart Diseases: Imaging Comes to Cardiology.* Wisconsin Center, Madison. Sponsored by Department of Medicine, Cardiology Section, and Department of Radiology, and Continuing Medical Education, University of Wisconsin Medical School; with University of Wisconsin Hospital and Clinics. AMA Category I and University of Wisconsin CEUs—both 12 hours. AAFP Prescribed and AOA Category 2-D—both 9½ hours. Contact: Sarah Aslakson, Continuing Medical Education, 610 Walnut St, 465B Madison, Wisconsin 53705; ph 608/263-2856. 10/85

OTHERS

OCTOBER 1985 (Minnesota): *Continuing medical education programs,* University of Minnesota Medical School, Minneapolis. See details in full-page ad elsewhere in this section. g10/85

NOVEMBER 1985 (Minnesota): *Continuing medical education programs,* University of Minnesota Medical School, Minneapolis. See details in full-page ad elsewhere in this section. g10/85

NOVEMBER 14-16, 1985 (Minnesota): *Clinical Strategies In Primary Care Medicine,* Radisson Plaza Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-10/85

DECEMBER 4-6, 1985: (Illinois): *Neurology for the Non-Neurologist,* The Westin Hotel, Chicago. Contact: University Office of Continuing Education, Rush University, 600 S Paulina, Chicago, IL 60612; ph 312/942-7095. p9-11/85

DECEMBER 5-7, 1985 (Minnesota): *Coronary Heart Disease: A Comprehensive Review of Principles and Practice,* Sheraton

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE tor listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

Wisconsin Society Medical Assistants

An affiliate of the American Association of Medical Assistants, Inc

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Saturday, November 9
Marshfield Clinic
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FEBRUARY 13-14, 1986 (Michigan): *Tenth Annual Winter Pediatric Conference* at Powderhorn Ski Area, Ironwood, Michigan. Guest speaker is James A Stockman, III, MD. Info: Marshfield Medical Education Department or H James Nickerson, MD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wisconsin 54449. 9-12/85; 1-86

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- Wisconsin Society of Radiation Oncology, Oct 18-19, 1985, Concourse Hotel, Madison
- Wisconsin Dermatological Society, Oct 26, 1985, Froederdt Memorial Lutheran Hospital, Milwaukee
- Wisconsin Orthopaedic Society, Nov 1, 1985, The Olympia Resort, Oconomowoc
- Wisconsin Society of Pathologists, Nov 16, 1985, American Club, Kohler
- Wisconsin Chapter American College of Surgeons, Dec 7, 1985, Marc Plaza Hotel, Milwaukee
- Wisconsin Urological Society, Apr 11-12, 1986, Edgewater Hotel, Madison
- Wisconsin Academy of Family Physicians, June 11-14, 1986, Telemark Lodge, Cable
- Wisconsin Society of Obstetrics & Gynecology, July 17-19, 1986, Embassy Suites, Green Bay
- Wisconsin Dermatological Society, Aug 1-3, 1986, The Abbey, Lake Geneva

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AMA

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JUNE 15-19, 1986: Annual AMA House of Delegates, Chicago, IL. ■

ADVERTISERS

Abbott Northwestern 8, 9
Acme Laboratories 51
Advanced Technology Associates, Inc 4
Medical Computer Systems
Air Force Medicine 7
American Physicians Life 14
Dista Products Co (Div of Eli Lilly & Co) 40
Ceclor®
Dorsey Pharmaceuticals (Div of Sandoz, Inc) 29, 30
Hydergine® LC
Gaarder Miller Milwaukee Ltd 33
House of Bidwell 48
Knoll Pharmaceuticals Company 36, 37, 38
Isoptin®
Marion Laboratories 41, 42
Cardizem®
Medical Protective Company 43
Minnesota, University of 57
Continuing Medical Education
Navy Medicine 30
PBBS Equipment 10
Peppino's 46
Physician and Sportsmedicine, The 46
Professionals Insurance Company, The 52
Roche Laboratories ..... 59, BC
Dalmane®
SK&F Company 35
Dyazide®
S&L Signal Company 51
SMS Services, Inc 34
Upjohn Company, The 39
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(selected courses)

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APRIL 14th-15th	Current Concepts in Refractive Surgery
APRIL 28th-MAY 2nd	Family Practice Review: Update '86
MAY 7th-9th	WorldMed '86: International Health Care Congress (sponsored by Minnesota Trade Office and Medical Alley Association)
7th-9th	43rd Annual Course in Allergy and Clinical Immunology
20th	Symposium on Gynecologic Oncology
21st-23rd	Current Concepts in Radiation Therapy
JUNE 6th-7th	15th Annual Workshops on Clinical Hypnosis - Introductory and Advanced
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CHANGES MADE IN UNPROFESSIONAL CONDUCT DEFINITION. As published in the *Wisconsin Administrative Register,* September 30, 1985, the Wisconsin Administrative Code definition of unprofessional conduct (Chapter **Med** 10) has been changed to include one new provision and expand another. Under the new code, former 10.02(2)(o) which prohibited solicitation, now reads:

> [unprofessional conduct is defined to mean and include] engaging in uninvited, in-person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence; or engaging in false, misleading or deceptive advertising.

In addition, the Code includes as unprofessional conduct:

> (t) Aiding or abetting the unlicensed practice of medicine or representing that unlicensed persons practicing under supervision, including unlicensed M.D.'s and D.O.'s, are licensed, by failing to identify the individuals clearly as unlicensed physicians or delegates.

It should be remembered that this section defining unprofessional conduct is not intended to be exclusive—the Medical Examining Board is not limited to examining only those complaints charging conduct listed in this Code section. For the original definition of unprofessional conduct, see the June 1985 ***WMJ,*** page 92.■

PRESIDENT REAGAN'S TAX REFORM PLAN would lower the top tax rate by broadening the tax base, reports the September 4 *AMA Newsletter.* While the AMA generally supports the proposal's objectives, it expressed strong opposition to provisions that would change accounting methods for medical practices and might lessen the value of physicians' retirement savings. The plan, which was unveiled May 28, would eliminate numerous tax credits, deductions, and exclusions, and lower the tax rates for both individuals and corporations. It would replace 14 current individual income tax rates—ranging from 11% to 50%—with three rates of 15%, 25%, and 35%. Corporate rates would drop from a maximum of 46% to 33%. In a statement, the AMA told the Senate Finance Committee and the House Ways and Means Committee that it strongly opposed a plan to limit the use of the cash method of accounting and mandate the use of the accrual method. The Association also opposed a plan to require that accounts receivable be taxed during the same year they were generated. The latter requirement would cause cash flow problems for many medical practices, especially where collections are difficult. 'Treasury II,' as the President's plan is called, would impose undesirable restrictions on qualified retirement plans and discourage people from saving for retirement. 'We believe that government policy should encourage retirement savings,' the Association said.■

FUTURE PARTICIPATION RATES in Medicare will depend to a large extent on federal marketing efforts for participating physicians and the impact of the fee freeze on nonparticipating physicians, the AMA Center for Health Policy Research said. The center reached its conclusion after a study of economic factors in physicians' decisions last year about whether to sign up for the Medicare participating physician program. In a sample of 476 nonfederal patient care physicians, the center found that the physicians who were more likely to participate last year were those who had previously assigned a larger percentage of patients or whose usual fees were relatively close to the Medicare prevailing fee (a high ratio). The higher the past assignment rate, the more likely the physician was to participate. A 1% increase in past assignment rates increased the probability of participation by a little more than one-half percent. As expected, the more the physician's usual fee was covered by the prevailing charge, the more likely he was to participate. A 1% increase in the ratio of the Medicare prevailing fee to the physician's usual fee increased the probability of participating by one-tenth of one percent. Overall, the likelihood that any physician would participate last year was a little more than one-third, with urban and non-board-certified physicians nearly twice as likely to participate as their rural or board-certified colleagues. The more heavily urbanized northeast and north central regions of the United States had larger participation rates than the more rural south and west. Internists, psychiatrists, anesthesiologists, radiologists, and pathologists had the highest participation rates. Surprisingly, one-fifth of those physicians who assigned no patients in the past decided to participate, and nearly one-fourth of those who previously had assigned all patients decided not to participate.■

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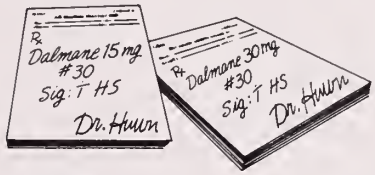

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SB 328 and medical malpractice

President Scott in his President's Page reiterates what Dr William Listwan told a Senate committee at a recent hearing on SB 328: "Skyrocketing costs of medical malpractice insurance do not represent merely a 'pocketbook' issue for physicians. It is a matter of escalating expenses for the consumer with the potential for creating a further crisis in the availability and affordability of healthcare." (See page 5)

Gratifying response

Medical Editor Falk in the Editorials section expresses the views of the medical community generally when he states: "It was a gratifying response to the Society's Physicians Alliance when on October 9 approximately 800 physicians from all over the state attended a reception for the entire Wisconsin State Legislature . . . The legislators should have been impressed by the sheer number of physicians present and their unusual unity as well as their sincerity and concern relative to the malpractice problem at the grass roots level. (See page 6)

In vitro fertilization and embryo transfer

A group of Waukesha physicians report their initial results of the in vitro fertilization program at their hospital. In the initial series of 20 patients, a pregnancy rate of 35% per embryo transfer was achieved. New methods are described to decrease the loss of concepti following embryo transfer. (See page 9)

NOVEMBER
1985

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CONTENTS

November 1985

SPECIAL FEATURES

President's Page

5 SB 328 and medical malpractice
John K Scott, MD
Madison

Editorials

6 Gratifying response
Victor S Falk, MD
Edgerton

6 It made me sick
Victor S Falk, MD
Edgerton

6 Never, never, never
Victor S Falk, MD
Edgerton

6 Noble work recognized

7 Non-nurse midwives
Victor S Falk, MD
Edgerton

Socioeconomics

42 SMS Liability Task Force chairman testifies

42 SPOTLIGHT ON SB 328: Ten statewide press conferences in two days

43 Medicare participating physician program clarified

Public Health

44 Traveler's Diarrhea

Miscellaneous

44 BLUE BOOK Update

46 AMA Physician's Recognition Award Recipients

News you can use

56 Effects of an extended fee freeze

56 CME credit deadline approaching

56 Insurance rates higher for some Michigan physicians

56 Quack cures

56 Volunteer relief activities in Mexico City

56 Physician service opportunities overseas

SCIENTIFIC MEDICINE

9 In vitro fertilization and embryo transfer
K Paul Katayama, MD, PhD; Mark Roesler, MS; Cindy Gunnarson, RN; Gloria M Halverson, MD; and *Matthew A Meyer, MD,*
Waukesha

11 Severe bullous emphysema and contralateral bronchogenic carcinoma . . . Successful management with staged bilateral thoracotomy
Kevin T Johnson, MD and *Akira Funahashi, MD, PhD*
Milwaukee

14 ABSTRACT: Farm accidents in children
Thomas H Cogbill, MD, Henry M Busch Jr, MD, and *Gary R Stiers, MD*
La Crosse

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Vol. 84 No. 11

CONTENTS

14 ABSTRACT: The incidence of rebleeding in traumatic hyphema
George J Witteman, MD, Stephen J Brubaker, MD, Max Johnson, MD, and *Ronald Marks, PhD*
Wausau, La Crosse, and Marshfield, Wisconsin and University of Florida

15 Malignant posttraumatic hypermetabolic syndrome associated with brain injury
Philip J Dahlberg, MD; Thomas H Cogbill, MD; Byron L Annis, MD; and *William M Deering, MD*
La Crosse

ORGANIZATIONAL

21 Reception brings 800 physicians and 100 legislators together

21 SMS Annual Meeting plans underway

21 New Communications Coordinator named

22 1984 MEMBERSHIP SURVEY: Members want greater emphasis on public image of profession

24 Membership encouraged for residents and students

24 Dues payment options available

25 Reduced Practice or Retired membership classifications

25 Spouse physicians take note

25 Wisconsin Association of Senior Physicians met November 9

26 Membership facts

30 Membership Directory—Update

46 CES FOUNDATION: Contributions during September 1985

DEPARTMENTS

45 PHYSICIAN BRIEFS

49 SPECIALTY SOCIETIES: American Congress of Rehabilitation Medicine, American College of Radiology, American College of Physicians, Wisconsin Society of Internal Medicine, Council of the American College of Surgeons–Wisconsin Chapter, American College of Physicians, and Milwaukee Ophthalmological Society

50 COUNTY SOCIETIES: Adams-Marquette-Columbia . . . Brown . . . Rusk . . . Winnebago

51 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Miscellaneous . . . Medical meetings/Continuing Medical Education . . . Books received . . . Advertisers■

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 6200 member physicians in Wisconsin, comprising 55 county medical societies and 26 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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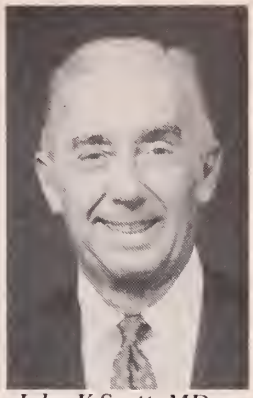
SB 328 and medical malpractice



John K Scott, MD

Skyrocketing costs of medical malpractice insurance do not represent merely a "pocketbook" issue for physicians.

It is a matter of escalating expenses for the consumer with the potential for creating a further crisis in the availability and affordability of healthcare.

This was the gist of a statement by William Listwan, MD, West Bend, in testimony before the State Senate Committee on Labor, Business, Veterans Affairs and Insurance. Doctor Listwan spoke for the Society's Liability Task Force in support of proposed Senate Bill 328 which addresses several aspects of the medical malpractice issue including placing a cap on malpractice awards. SB 328 also:

—imposes toughter sanctions on doctors:
—strengthens the peer review system for physicians;
—imposes tougher sanctions on doctors;
—strengthens the peer review system for physicians;
—requires itemized damages in verdicts in malpractice cases; and
—provides a clear and complete definition of medical expenses.

SB 328 proposes a $3.3 million cap on all malpractice awards. The State Medical Society's proposed amendment seeks a $1 million cap on "nonmedical" components of those awards but allows for unlimited payment of medical expenses incurred by patients who succeed in proving claims against physicians.

"Nonmedical" expenses are typically understood to include such components as: pain and suffering; loss of society and companionship; and future earnings.

The purpose of the proposed $1 million award limit on nonmedical payments is to begin to find a means to hold the line on medical malpractice insurance premium costs which increased nearly 100 percent in 1985 alone. By imposing no limits on medical expense payments, the proposal ensures patients will receive due compensation for all injuries.

The Physicians Alliance Commission and the Liability Task Force of the State Medical Society have been very active in dialogue on SB 328. The diagram at the right shows the anticipated route of SB 328 through the Legislature and to the Governor's desk to be signed into law in an acceptable form. "The mills of justice grind slowly, but they grind exceedingly fine."

Tremendous expenditures of time and effort on behalf of the State Medical Society members and Auxiliary are necessary to bring SB 328 through the legislative process. You know your immediate task: to contact your State Senator and State Representative to explain why they should support the Society's position on medical liability. Let's all pull together now, and in the future, as calls come from our Society.■

SENATE BILL 328: Developed by Legislative Council *Special Committee on Medical Malpractice*—August 1984-May 1985. (Chairman: Senator Jerome Van Sistine)

Reported to: *Legislative Council*—voted to introduce *SB 328* in June 1985.

Referred to: *Senate Committee on Labor, Business, Veterans Affairs and Insurance* (Chairman: Senator Jerome Van Sistine)—public hearing held Oct 2, 1985

October 18, 1985: Floor period ended.
—Additional public hearing may be held.
—Committee meets in executive session to vote on recommending passage of bill; may consider and recommend amendments.

Referred to: *Joint Committee on Finance* (Cochairs: Senator Gary George and Representative Marlin Schneider)
—Committee meets in executive session to vote on recommending passage of bill; may recommend amendments.

Referred to: *Senate Organization Committee* (Five members, Democratic and Republican leadership)
—Committee schedules bill for floor action in Senate.

January 28, 1986: Floor period begins.

Full Senate action: If Senate adopts SB 328, with or without amendments, the bill as passed by the Senate is sent to the *Assembly.*

Referred to: *Assembly Committee on Financial Institutions and Insurance* (Chair: Representative Tom Hauke)
—Committee may hold public hearings
—Committee takes executive action on the bill, if the chairman schedules the bill for executive session.
—Committee recommends passage of bill and amendments.

Referred to: *Assembly Rules Committee*
—Committee schedules bill for floor action in Assembly.

Full Assembly Action: *Reconciliation of Assembly and Senate versions*
—If different, either house may concur in the other house's changes; or, the bill may be sent to a conference committee.

Governor signs bill into law

March 26, 1986: 1985 Legislature adjourns.

January 1987: 1987 Legislature convenes.

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

Gratifying response

IT WAS A gratifying response to the Society's Physicians Alliance when on October 9 approximately 800 Wisconsin physicians from all over the state attended a reception for the entire Wisconsin State Legislature. This was an opportunity to informally meet with the state legislators in regard to the malpractice situation.

One physician who was present indicated that he had opted for early retirement when he received his bill for $24,000 for coverage as a general surgeon. Another pessimistic physician who did not attend stated that he did not anticipate any progress "until the whole system collapsed."

The legislators should have been impressed by the sheer number of physicians present and their unusual unity as well as their sincerity and concern relative to the malpractice problem at the grass roots level.

—*Victor S Falk, MD,* Edgerton

It made me sick

RECENTLY I TALKED with a 15-year-old high school freshman. He had been dropped from the football squad just the day before for drug abuse and had sought help of his own volition.

He stated that he had begun using marijuana while in second grade. I questioned him about the source and he said it was readily available from older people around the schoolyard. This really sickened me.

He said he financed the purchase of marijuana by taking money from his mother's purse and she never noticed the missing money. He also started drinking beer on weekends to the point of intoxication beginning in 7th grade. Initially he would have an older person procure the beer for him. Since he was now 15, he could buy it over the counter himself. In addition he smokes a pack of cigarettes daily.

The whole story is distressing, but the availability of drugs to children in the lower grades seems particularly disgraceful. This pleasant, outgoing young man's parents had no idea that he was involved with either marijuana or beer until he turned himself in. I'm sure there must be someone observant enough around the grade school environment to detect the low form of animal life that pushes drugs onto children.

—*Victor S Falk, MD,* Edgerton

Never, never, never

SUPREME COURT Chief Justice Burger periodically comes down rather hard on the legal profession. He particularly dislikes lawyer advertising and calls it "sheer shysterism."

He is quoted as saying "I will say never—my advice to the public is—never, never, never under any circumstances engage the services of a lawyer who advertises." The Chief Justice would certainly take a dim view of the morning and evening TV lawyers' commercials here in Wisconsin.

But what would he think of advertising physicians? Confronted with full-page newspaper ads, billboards, and radio and TV spots all touting competing HMO plans, he might have trouble finding medical care in Wisconsin that has not been commercialized by some form of advertising.

—*Victor S Falk, MD,* Edgerton

Noble work recognized

SINCE THE Nobel Prize for peace was established in 1901, it has been awarded only six times to organizations. This past month the prize went to the International Physicians for the Prevention of Nuclear War.

With it came well deserved recognition of those physicians of the world who by their unique and persistent concern for humanity have made seminal contributions to the world's understanding and perception of the life and health consequences of nuclear explosion. Many, even among the medical profession, realize that the prime activist group within the IPPNW is the organization known as the Physicians for Social Responsibility (PSR).

In Wisconsin this group numbers several hundreds of members. In 1982 they carried their concerns to the State Medical Society's House of Delegates and won an official commitment by the Society to educate physicians and the public to the public health consequences of nuclear explosion. There is now an ongoing committee of the Society dedicated to this task. It has sponsored lectures and seminars. It helped bring a delegation of Society physicians to Wisconsin to dialogue with government officials, physicians, and others. The Society hosted an overflow crowd for dinner and talks with their Russian counterparts.

It is more than interesting to note that the State Medical Society of Wisconsin is alone among the hundreds of county, state, and national medical groups comprising so-called "organized medicine" to join this unusual and highly successful peace movement. Equally

notable is the fact that the Society's current President John K Scott, MD, Madison, was the vanguard for the Society's involvement. At the time he took on this task of leadership there were hints of suspicion *a la* Joe McCarthy. Support came reluctantly. But persistence and dedication paid off. It is a cause which humanity must not deny.

Thank you, Doctor Scott, for your insight and courage. Similar appreciation goes to your colleagues in the PSR, whether SMS member or no. Perhaps now your efforts will speak with a louder voice to be heard and listened to by an ever widening audience.

Non-nurse midwives

MANY SPECIALISTS in the field of obstetrics and gynecology have recently limited their practices to gynecology alone and have discontinued obstetrics. The obvious reason for this is the high cost of premiums for obstetrical coverage for so-called malpractice. In the Miami, Florida area for example, the annual premium for obstetricians is $123,000. It is understandable why this would prove overwhelming for many obstetricians.

Now a bill has been proposed in the Wisconsin Senate to license non-physician, non-nurse midwives. The low level criteria for licensure include only high school graduation or equivalent, being age 18 or over, completing a course of study and passing an examination established by the Department of Regulation and Licensing. There are also some very limited requirements for physician backup or supervision.

There is a strong lobbying campaign in support of the bill that stresses the concept of women's right to choose their method of delivery.

On the basis of previous experience with unlicensed midwives illegally functioning within a few miles of our state capital, there will inevitably be some outcomes affecting both the mother and the infant that are less than desirable. The past experience has been that these previously unlicensed midwives resented and resisted medical help even in emergencies.

One wonders what sort of malpractice insurance coverage these lay midwives would have if the proposed bill would unfortunately pass the Senate. Perhaps the women seeking this type of care might be more sympathetic to lay midwives than to "wealthy doctors and big insurance companies" that they assume can easily afford to pay.

—*Victor S Falk, MD,* Edgerton ■

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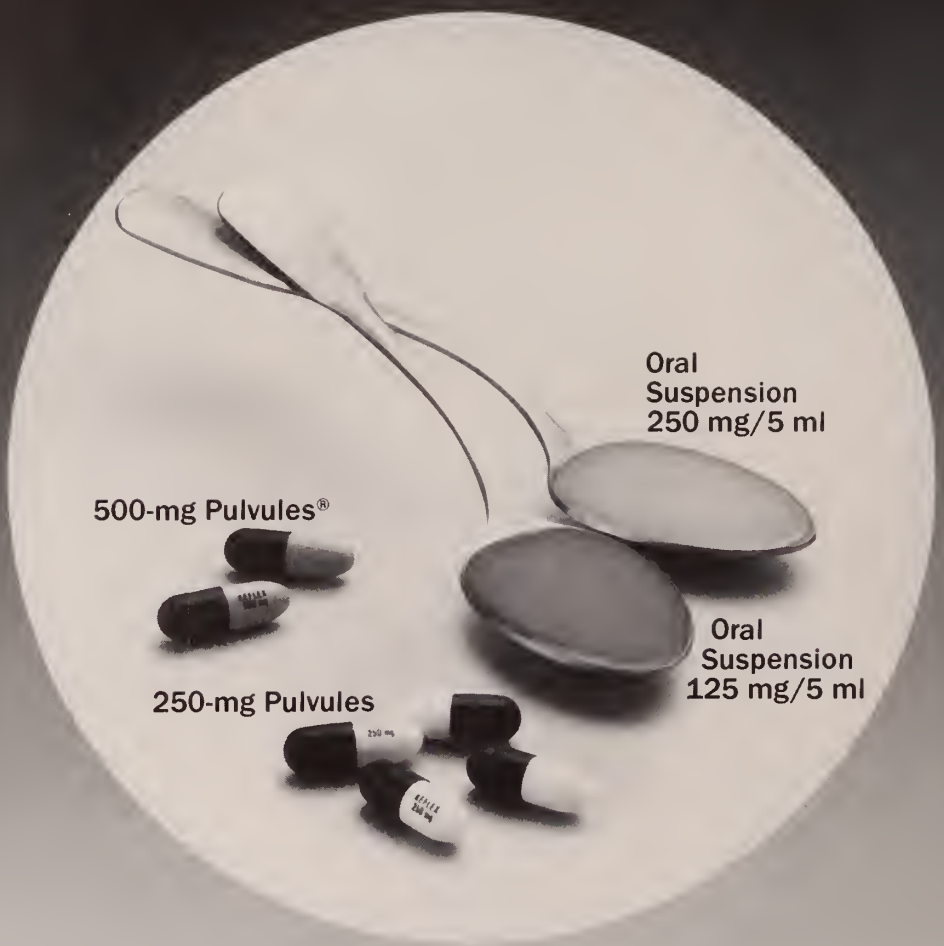

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In vitro fertilization and embryo transfer

K Paul Katayama, MD, PhD; Mark Roesler, MS; Cindy Gunnarson, RN; Gloria M Halverson, MD; and *Matthew A Meyer, MD,* Waukesha, Wisconsin

ABSTRACT. ***Initial results of the in vitro fertilization program at Waukesha Memorial Hospital are presented. In the initial series of 20 patients, a pregnancy rate of 35% per embryo transfer was achieved. New methods are described to decrease the loss of concepti following embryo transfer.***

Key words: In vitro fertilization; Embryo transfer; Ritodrine

SINCE THE FIRST in vitro child was born in England in 1978, in vitro fertilization (IVF) programs have been initiated in many institutions throughout the world. The first program in America was started in Norfolk, Virginia in 1980.

In 1984 the first IVF program in Southeastern Wisconsin was established at Waukesha Memorial Hospital. We report here on the initial results of this program.

Indication for IVF. The incidence of infertility has increased in recent years. As a result of this and of the lack of availability of infants for adoption, there is an increased need for infertility therapy. In some instances IVF is the only therapy which can be offered to an infertile couple. At this hospital we have been able to help a number of these couples.

The indications for IVF at leading institutions around the world[1] and in our program include:

1. absent or irreparably damaged fallopian tubes;
2. oligoasthenospermia;
3. endometriosis refractory to conventional therapy; and
4. idiopathic infertility of long duration.

Materials and methods. Patients for the IVF program were selected, following a comprehensive infertility workup, on the basis of the above indications, and after review by the IVF Committee, which consists of obstetrician-gynecologists and is directed by a Board-certified reproductive endocrinologist. Twenty patients have been accepted for the IVF program.

Each patient received two to three ampules of human postmenopausal gonadotropins (Pergonal®) intramuscularly starting on the third day of the menstrual cycle. Patients were monitored by hormonal assays, ultrasound examinations of follicular development, and examination of uterine cervical mucous changes in response to rising estrogen. After proper follicular stimulation was accomplished using Pergonal® , each patient received 10,000 IU of human chorionic gonadotropin (hCG) intramuscularly. Thirty-six hours later, oocyte retrieval was accomplished by laparoscopic procedure.

The oocytes were placed in culture media consisting of Ham's F-10 supplemented by human serum. Sperm obtained from the patient's husband were capacitated by a washing process which involved suspension in Ham's F-10 solution and repeated centrifugation. Insemination was carried out four to eight hours after egg retrieval. Two days later all of the concepti were transferred by a thin transfer catheter through the cervix to the patient's uterus.

The patients were divided into two series. Patients in Series I received no premedication prior to transfer and were discharged four hours after transfer. In Series II, patients received 10 mg of ritodrine orally, and 50 mg of meperidine and 10 mg of diazepam, intramuscularly, one hour prior to transfer. Patients in the second series were kept in bed for 24 hours following transfer and were instructed to remain in bed for four days following discharge.

Results. ***Series I.*** Egg retrieval was successful in six out of seven patients in this series. One to four

Table 1—*Results of the IVF Program at Waukesha Memorial Hospital*

	Number of patients	*Number of embryo transfers*	*Number of pregnancies*	*Pregnancy rate (%) (pregnancy per embryo transfer)*
Series I	7	6	0	0
Series II	13	11	6	54
TOTAL	20	17	6	35

From Waukesha Memorial Hospital, Waukesha. Reprint requests to: K Paul Katayama, MD, Waukesha Memorial Hospital, 725 American Ave, Waukesha, Wis 53188 (ph 414/544-2722). Copyright 1985 by the State Medical Society of Wisconsin.

fertilized and cleaved eggs were transferred in each of these six patients. There were no pregnancies in this group (Table 1).

Series II. In Series II, there were 13 patients. Egg retrieval was successful in 11 of these patients. One to four concepti were transferred in each of these 11 patients. In this group of 11, there were two biochemical pregnancies and four clinical pregnancies which are ongoing (Table 1).

Case history. A 28-year-old married, white female, para 0, was referred for her primary infertility of four years' duration. She consented to this publication of her case history. Complete evaluation of infertility disclosed obstruction of fallopian tubes. In April 1984 the patient had undergone an exploratory laparotomy which disclosed large hydrosalpinx on the left and torsion of the right hydrosalpinx. Restoration of functional fallopian tubes was thought to be impossible, and bilateral salpingectomy was carried out. The ovaries were suspended to the sides of the uterus by the referring physician to facilitate future in vitro fertilization attempts.

Table 2—*Pregnancy rate per embryo transfer*

IVF Center	*Percentage*
Sendai, Japan[2]	10
Uppsala, Sweden[3]	11
Vienna, Austria[4]	17
Melbourne, Australia (Trouson, et al)[5]	19
Los Angeles, California, USA (Marrs, et al)[6]	19
Melbourne, Australia (Lopata)[7]	20
New Haven, Connecticut, USA[8]	20
Clamart, France[9]	21
Adelaide, Australia[10]	21
Houston, Texas, USA[11]	21
Norfolk, Virginia, USA[12]	26
Bourn Hall, UK[13]	29
Waukesha, Wisconsin, USA (Series II)	54

On the third day of her menstrual cycle in January 1985, the patient received two ampules of Pergonal® intramuscularly. By the 13th day of her menstrual cycle, follicular size had reached 15 mm in diameter. Her estradiol value was 928 pg/ml. At that time she was given 10,000 units of human chorionic gonadotropin (hCG) intramuscularly. Thirty-six hours later laparoscopy was carried out under general anesthesia and three eggs were retrieved. Two eggs were fertilized and cleaved. Two days later embryo transfer was carried out. Singleton pregnancy has been established, and the patient is due in October 1985.

Discussion. In well-established clinics around the world fertilization and embryo transfer occur in about 80% of patients subjected to laparoscopy. Our results are consistent with those figures.

However, all published results reflect a significant loss of concepti following embryo transfer. Currently the rate of pregnancy as a percentage of transfers at major IVF centers ranges from 10% to 29% (Table 2).[2-13]

In our second series we utilized new and hitherto unreported approaches in an effort to decrease the loss of concepti following transfer. To minimize the uterine contractions, which are constantly occurring in females of reproductive age, we administered a B_2 receptor agonist, ritodrine, to impede the biochemical processes contributing to uterine contractions.

Since implantation of a fertilized egg does not occur in the human female until seven days following conception, we modified our protocol so as to keep patients as much as possible at rest during the pre-nidation period. Patients were kept in the hospital for 24 hours following transfer and instructed to get as much bed rest as possible following discharge. They were also instructed to remain as much as possible in a position whereby gravity might assist the uterus in retaining the concepti. In other words, patients whose uteri were anteverted were instructed to remain on their abdomens. Patients whose uteri were retroverted were instructed to rest in a dorsal position.

The pregnancy rate as a percentage of transfers in our second series compares very well with that of programs worldwide (Table 2). Since our second series is small, the pregnancy rate may change as the series grows. Nevertheless, we believe that the methodologies described here may play some part in the achievement of that pregnancy rate.

Addendum. On September 22, 1985 the patient referred to in the text delivered a normal male infant.

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Severe bullous emphysema and contralateral bronchogenic carcinoma . . . Successful management with staged bilateral thoracotomy

Kevin T Johnson, MD and *Akira Funahashi, MD, PhD,* Milwaukee, Wisconsin

ABSTRACT. ***There is an increased incidence of bronchogenic carcinoma among the patients who have pulmonary bullous disease. A case is presented in which a large bullous lesion and a bronchogenic carcinoma occurred simultaneously in the opposite lungs. The patient was successfully treated by bilateral thoracotomy.***

Key words: Bronchogenic carcinoma; Pulmonary bullous disease; Emphysema

LARGE PULMONARY bullae usually occur in association with chronic obstructive lung disease and a bullectomy is an accepted method of treatment for selected cases. Patients who have pulmonary bullous disease also appear to have an increased incidence of bronchogenic carcinoma.[1,2] In these patients resectional surgery for bronchogenic carcinoma is often difficult because of the limited pulmonary reserve. When a carcinoma is contiguous to an area of bullous disease, a resection of the tumor together with bullous tissue may be performed; and this has been described previously.[1,3] We report a case with a large bullous lesion associated with a bronchogenic carcinoma in the contralateral lung. The patient was successfully treated by a bullectomy followed by resection of the carcinoma. To our knowledge this is the first case in which a giant bulla and bronchogenic carcinoma occurred simultaneously in opposite lungs and were treated by bilateral thoracotomy.

From the Department of Medicine, Veterans Administration Medical Center, Milwaukee (Wood), and the Medical College of Wisconsin, Milwaukee. Doctor Johnson is a Fellow in pulmonary diseases; Doctor Funahashi is a Professor of Medicine. Publication support provided. Reprint requests to: A Funahashi, MD, 111E, VA Medical Center, 5000 West National Ave, Milwaukee, Wis 53193 (ph 414/384-2000). Copyright 1985 by the State Medical Society of Wisconsin.

Case report. A 51-year-old male presented to the Veterans Administration Medical Center in Milwaukee, Wisconsin on Nov 22, 1980 with a one-year history of progressive dyspnea, a four-month history of a cough productive of blood-tinged sputum, a 25-pound weight loss, and an intermittent achy left-sided chest pain. His medical history was remarkable for alcohol abuse and chronic obstructive pulmonary disease (COPD). He had smoked one to two packages of cigarettes daily for 35 years. History was remarkable for significant occupational asbestos exposure from 1966 to 1980. Physical examination was remarkable for finger clubbing, localized wheezing in the left lower posterior thorax, and decreased breath sounds with hyperresonance to percussion in the upper two-thirds of the right hemithorax. Admission laboratory examination was normal except for minimal elevation of alkaline phosphatase and gamma-glutamyl transpeptidase. Repeat liver function studies and liver-spleen scan one week later were normal. The admission chest roentgenogram (Fig 1-A) revealed a large bullous lesion occupying 80% of the right hemithorax with compression of the residual right lung and a left-sided retrocardiac density. Tomograms of the left hilum confirmed the presence of a left retrocardiac mass. Cytologic examination of expectorated sputum was negative for malignant cells.

Flexible fiberoptic bronchoscopy demonstrated a vascular, polypoid mass occluding the superior segment bronchus of the left lower lobe, and a biopsy revealed squamous cell carcinoma. Pulmonary function studies demonstrated moderate obstructive

Figure 1(A)—*Admission posteroanterior chest roentgenogram demonstrating a large bullous lesion occupying 80 percent of the right hemithorax with compression of the residual right lung and a left-sided retrocardiac density.*

Figure 1(B)—*Posteroanterior chest roentgenogram after right upper bullectomy demonstrating significant reexpansion of the right lung.*

Figure 2(A)—*Preoperative pulmonary perfusion scan with technetium^{99} macroaggravated albumin.*

Figure 2(B)—*Perfusion scan after right upper lobe bullectomy.*

ventilatory impairment with a forced vital capacity (FVC) of 2.91 L (71%) and a forced expiratory volume at 1 second (FEV_1) of 1.79 L (58%). Pulmonary perfusion scan with 4 mCi technetium^{99} macroaggregated albumin (Fig 2-A) demonstrated marked decrease in perfusion of the right lung field, except for the base, and a perfusion defect in the left midlung zone. Pulmonary ventilation scan with inhalation of 16 mCi zenon^{133} radioactive gas revealed decreased ventilation of the right lower lung field with air trapping in the entire right lung in the washout phase and a delayed ventilation in the left middle lung zone. These studies indicated a limited contribution of the right lung to his overall pulmonary function and that the patient would not be able to tolerate a left lower lobectomy without improvement of the right lung function.

On Dec 11, 1980, the patient underwent a right thoracotomy. The right lung bulla was stapled and excised. The residual two-thirds of the right upper lobe appeared normal and remained intact. The patient experienced dramatic symptomatic relief postoperatively, and the postoperative course was uneventful. Postbullectomy chest roentgenogram (Fig 1-B) revealed significant reexpansion of the right lung. Repeat pulmonary function studies demonstrated significant improvement of the FEV_1, which had increased from 1.79 to 2.46 liters. Ventilation and perfusion scans after the bullectomy also showed a considerable improvement in the right lung function. (Fig 2-B).

On Dec 30, 1980 a left lower lobectomy was performed. The resected bronchial margin was free of tumor, but two of seven lobar lymph nodes demonstrated metastases. The patient subsequently received radiation therapy to the mediastinum with 5,760 rads. Pulmonary function studies obtained on May 10, 1983 showed a moderate reduction in FVC (2.60 L) and FEV_1 (1.86 L), which was primarily attributable to the lobectomy. He died in February 1984 from acute liver failure at another hospital. An autopsy revealed no residual or metastatic carcinoma despite lobar lymph node metastases at the time of lobectomy.

Discussion. In spite of recent advancement of radiation treatment and chemotherapy, surgical resection still offers the greatest potential cure for primary nonsmall cell bronchogenic carcinoma. Unfortunately a significant proportion of patients is denied surgical resection at the time of diagnosis, because of poor pulmonary reserve. An obstructive impairment secondary to chronic obstructive airways disease is the most common cause of poor pulmonary reserve. In patients with pulmonary emphysema, the airway obstruction is usually irreversible. Occasionally, however, in selected patients with airway obstruction improvement in pulmonary function may result from surgical treatment. Surgical correction of tracheal strictures with upper airway obstruction is a well-established procedure. A severe airway obstruction due to compression of the left mainstem bronchus by an aneurysm also has been reported.[4] In this case a surgical resection of the aneurysm resulted in a dramatic clinical and functional improvement. Surgical removal of a giant pulmonary bulla, with compression of functional remaining lung tissue, also may result in significant improvement in pulmonary function. Selection of the cases, however, is not an easy task due to difficulty of assessing the degree of underlying generalized pulmonary emphysema. Many guidelines have been proposed for this purpose.[5,6]

The apparent association of bullous emphysema and bronchogenic carcinoma has been described previously.[1,2] Stoloff et al reported an incidence rate of lung carcinoma in men with bullous emphysema to be 6.1% compared to a 1.9% without bullous emphysema.[2] Goldstein et al found 16 cases, or a 3.9% incidence, of "giant bullous disease" in a total of 411 patients with bronchogenic carcinoma, while control groups showed an incidence of 1.7%.[1] As to the relationship of tumor and bullous lesion, there are conflicting reports. Stoloff found that in 6 (23%) of his 26 cases the tumor arose from within the bulla, while in 20 (77%), there was no special relationship to the bulla. Goldstein, however, found that in 15 out of 18, or 83.3%, of his cases the carcinoma was contiguous to an area of bullous disease.

Surgical resection of bronchogenic carcinoma in patients with bullous disease is difficult because of generally poor pulmonary function. In Goldstein's series there were 18 patients who had both bullous disease and bronchogenic carcinoma.[1] Only seven of those 18 cases had thoracotomies. Of the seven patients who underwent thoracotomies only two had resectional surgery. One died of metastasis and the other was lost to followup. Aronberg et al[3] reported three patients, under the age of 40, who had both bullous disease and bronchogenic carcinoma. Two patients had resectional surgery. In one of Goldstein's cases and two of Aronberg's cases the carcinoma was in the side where bullous changes were present. In Goldstein's other case the bullous change was described as "throughout" in both lungs. This patient had a right upper lobectomy. In the present case the squamous cell carcinoma developed in the opposite lung necessitating a bilateral thoracotomy.

In the present case a large bullous lesion was thought to be the

major reason of his pulmonary dysfunction. A bullectomy in the right side with significant improvement of pulmonary function allowed the patient to have left lower lobectomy for curative resection of the carcinoma. His carcinoma was cured in spite of metastasis to lymph nodes at the time of surgery, and there was no residual tumor at autopsy when the patient died from acute liver failure over three years after thoracotomy.

Although bullous change itself has been postulated as a cause of carcinoma in cases where carcinoma occurred in contiguous area of bullous disease, cigarette smoking and an asbestos dust exposure in our patient probably played a major role in the development of his carcinoma. This case illustrates the importance of recognizing a potentially correctable cause of pulmonary dysfunction before denying a patient for curative surgery for bronchogenic carcinoma.

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ABSTRACTS

The incidence of rebleeding in traumatic hyphema

GEORGE J WITTEMAN, MD; STEPHEN J BRUBAKER, MD; MAX JOHNSON, MD; and RONALD MARKS, PhD, The Eye Clinic of Wausau (GJW), Wausau, Wis; Gundersen Clinic Ltd (SJB), La Crosse, Wis; Marshfield Clinic (MJ), Marshfield, Wis; and The Biostatistics Unit (RM), University of Florida, Gainesville, Fla. *Ann Ophthalmol* 1985 (Sept): 17:525-529.

A collaborative, retrospective study of 371 consecutive hyphema patients reveals an overall 3.5% incidence of rebleeding without the use of antifibrinolytic agents. This is the single largest study of hyphema patients published. The rebleed rate is significantly lower than the 20%–33% rate of rehemorrhage reported in previous American studies. Numerous factors were reviewed on each patient, including age, sex, race, grade of hyphema, disposition, and the use of topical or systemic medications. Thirty percent of the patients were treated on an outpatient basis. The low incidence of rebleeding, particularly in less severe hyphemas (less than half the anterior chamber volume), does not support the routine use of systemic antifibrinolytics or corticosteroids. ■

Farm accidents in children

THOMAS H COGBILL, MD; HENRY M BUSCH JR, MD; and GARY R STIERS, MD, Departments of Surgery and Pediatrics, Gundersen Clinic Ltd/La Crosse Lutheran Hospital, La Crosse, Wis. *Pediatrics* 1985 (Oct); 76:562–566.

During a six and one-half year period, 105 children were admitted to the hospital as the result of trauma that occurred on farms. The mechanism of injury was animal related in 42 (40%), tractor or wagon accident in 28 (26%), farm machinery in 21 (20%), fall from farm building in six (6%), and miscellaneous in eight (8%). Injury Severity Score was calculated for each patient. An Injury Severity Score of greater than or equal to 25 was determined for 11 children (11%). Life-threatening injuries, therefore, are frequently the result of childhood activities that take place in agricultural environments. The most common injuries were orthopedic, neurologic, thoracoabdominal, and maxillofacial. There was one death in the series, and only one survivor sustained major long-term disability. Such injuries are managed with optimal outcome in a regional trauma center. Educational programs with an emphasis on prevention and safety measures may reduce the incidence of farm accidents. ■

Malignant posttraumatic hypermetabolic syndrome associated with brain injury

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ABSTRACT. ***Malignant posttraumatic hypermetabolic syndrome (MPHS) developed in seven brain-injured patients. A characteristic constellation of symptoms included severe muscle rigidity, diaphoresis, tachycardia, tachypnea, and fever. Complications of the syndrome were marked weight loss, volume depletion, hypernatremia, renal failure, orthopedic injuries, and death. The entire symptom complex could be reversed with pancuronium bromide or diazepam administration. The clinical features and response to muscle relaxants closely resemble other disorders in which muscle contracture is a dominant feature. These include malignant hyperthermia, tetanus, strychnine poisoning, and the neuroleptic malignant syndrome. This suggests that intense prolonged muscle contracture is of pathogenetic importance and should be addressed in the management of the syndrome.***

Key words: Malignant posttraumatic hypermetabolic syndrome; Brain injury; Vegetative syndromes

A VARIETY OF vegetative syndromes have been described following severe brain injury. In the acute phase these include frontobasal syndrome, diencephalic crisis, and acute, secondary midbrain syndrome. These are characterized by profound neurologic deficits, decerebrate or decorticate rigidity plus paroxysms of extensor spasms, diaphoresis, tachycardia, tachypnea, hyperthermia, and hypertension. Metabolic abnormalities include increased catecholamine excretion, oxygen consumption, and a markedly negative nitrogen balance.[1,2] Survival of the acute phase may be followed by a transitional period. In this stage paroxysms become less frequent, less intense, and may only occur after external stimulation.[2]

Hyperthermia has been attributed to hypothalamic injury, loss of heat dissipation mechanisms, or stimulation of heat production. The cardiovascular and respiratory changes seen in these syndromes may be partially due to a combination of increased catecholamine excretion and loss of vegetative inhibition from disturbed diencephalic function.[3] The hemodynamic response to severe head injury was recently reevaluated by Clifton et al.[4] They found increases in cardiac output, blood pressure, pulse, and oxygen consumption all correlated with increased catecholamine excretion. Beta-blocking agents were successful in normalizing these hemodynamic changes.

Our experience with seven brain-injured patients suggests that hypothalamic injury and increased catecholamine excretion are not adequate explanations for all of the physiologic changes seen after brain injury. This report describes seven patients with a syndrome of severe muscle contracture, fever, tachycardia, and tachypnea. Response to muscle relaxants suggests that intense, sustained muscle contracture is of major pathogenetic importance. Because of the dramatic and potentially fatal nature of this syndrome, we have elected to call it the malignant posttraumatic hypermetabolic syndrome (MPHS).

Case reports. Seven case reports are summarized in Table 1. Two representative case reports are described below.

Case 4. A 19-year-old male was involved in a motor vehicle accident sustaining rib fractures and pneumothorax on the left side, pulmonary contusion, and severe head injury with decorticate posturing. A computerized tomographic (CT) scan showed thalamic hemorrhage on the left side.

A chest tube on the left side and intracranial pressure monitor were placed. Episodes of intense rigidity, decerebrate posturing, diaphoresis, tachycardia, tachypnea, and a temperature to 38.8 C developed two hours after admission. The patient was paralyzed with pancuronium bromide and placed on a ventilator with complete resolution of the syndrome. Two subsequent attempts at discontinuing pancuronium bromide led to an immediate recurrence of the syndrome (Fig 1).

Two weeks after admission pancuronium bromide and ventilation were discontinued. Increasing rigidity and posturing recurred followed by diaphoresis, fever (39-40 C), tachycardia, and tachypnea. Profound diaphoresis was associated with large in-

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Table 1—*Clinical features of malignant posttraumatic hypermetabolic syndrome*

	Cases						
	1	*2*	*3*	*4*	*5*	*6*	*7*
Age/Sex	15/F	17/M	24/M	19/M	16/M	30/M	16/M
Hypothalamic or thalamic injury	–	–	+	+	+	–	+
Rigidity	+	+	+	+	+	+	+
Diaphoresis	+	+	+	+	+	+	+
Tachycardia	+	+	+	+	+	+	+
Fever	+	+	+	+	+	+	+
Flushing	+	–	–	–	–	–	+
Creatine phosphokinase (units/liter)	ND	ND	ND	ND*	1142	850	505
Urine urea nitrogen (Gm/24 hours)	13	15	ND	15	ND	27	19.8
Complications							
Weight loss (Kg)	9.5	0	11.6	17.2	8.2	7.6	5.4
Volume depletion	–	–	+	+	+	–	–
Hypernatremia	–	–	+	+	–	–	–
Azotemia	–	–	–	+	–	–	–
Orthopedic	+	–	–	–	+	–	–
Death	–	–	+	+	–	–	–
Response to diazepam	ND	ND	ND	ND*	+	+	+

ND = not done
* = responded to pancuronium bromide

sensible fluid losses (estimated at 3 to 4 liters daily), hypernatremia (serum sodium 158 mM/liter) and prerenal azotemia (blood urea nitrogen 96 mg/dL). Urine urea nitrogen ranged from 15 to 20 Gm. During the 40-day hospitalization his weight fell 17.2 kg despite 3000 to 3600 kcal of enteral feedings daily.

Hypernatremia and azotemia initially responded to aggressive fluid and electrolyte replacement. The syndrome, however, was unrelenting and the patient died with serum sodium of 159 mM/liter and blood urea nitrogen of 120 mg/dL.

Case 6. A 30-year-old mentally retarded male was struck by an automobile and brought to the emergency room complaining of head pain. After arrival he suddenly lost consciousness, dilated both pupils, and developed decerebrate posturing. A CT scan showed a left frontotemporal extracerebral hematoma and an acute epidural hematoma which was immediately drained in the operating room. On the second postoperative day intracranial pressure rose to 30 torr and neurologic status deteriorated. Thirty ml of clot was evacuated on reexploration of the head.

Following the second operation the patient was decerebrate and had bilateral Babinski signs. Two days later he began having paroxysms of intense decerebrate rigidity, fever, diaphoresis, tachycardia, and tachypnea. Creatine phosphokinase was 850 units per liter, urine creatinine 2256 mg per 24 hours, and urine nitrogen 27 Gm per 24 hours. Intracranial pressures remained less than 20 torr. Diazepam, 5 mg intravenously every 6 hours, was given, with resolution of rigidity, paroxysms and normalization of creatine phosphokinase by the fifth day of treatment (Fig 2). Moderate rigidity recurred as diazepam dosage was tapered but there were no further paroxysms of diaphoresis, tachycardia or tachypnea, and creatine phosphokinase levels remained normal.

During the first month of hospitalization, weight decreased 7.6 kg despite 2400 kcal intake daily. He was discharged at four months with severe spastic quadraparesis.

Discussion. Malignant posttraumatic hypermetabolic syndrome (MPHS) occurring in seven brain-injured patients is described (Table 1). The onset within days after the initial insult is characterized by intense rigidity, posturing, diaphoresis, tachypnea, fever, and occasionally flushing. It is usually episodic and paroxysms are often precipitated by external stimuli. These episodes can be aborted and prevented with pancuronium bromide or large doses of diazepam. The natural history is variable. In some cases episodes spontaneously diminished and in others progression to a crisis-like state resulted in death.

Laboratory abnormalities associated with MPHS include modestly elevated creatine phosphokinase and marked increases in urine urea nitrogen. These are probably caused by intense muscle rigidity, muscle breakdown, and hypermetabolism. Creatine phosphokinase may prove useful in distinguishing MPHS from other hypermetabolic states (sepsis, meningitis) and may provide a means to assess therapy.

Complications observed in our patients included volume depletion, hypernatremia, and azotemia from large insensible fluid losses. Orthopedic injuries developed in two patients from intense, sustained muscle rigidity. Two deaths attributed to the syndrome—one from severe fluid losses leading to hypernatremia and renal failure and the other to severe hyperthermia.

Four other syndromes clinically resemble the MPHS (Table 2). These include malignant hyperthermia, tetanus, strychnine poisoning and the neuroleptic malig-

nant syndrome. Although they have widely different pathogeneses, each is characterized by muscle rigidity, fever, diaphoresis, and tachycardia. This suggests that sustained muscle contracture plays a role in generating the other manifestations of these syndromes including fever, increased oxygen consumption, muscle necrosis, renal failure, and bone and joint injuries. Muscle relaxants have a beneficial effect on these syndromes, regardless of whether muscle rigidity is centrally or peripherally mediated.

Malignant hyperthermia is an inherited disorder of muscle metabolism. Extreme muscle hypermetabolism is precipitated by exposure to volatile anesthetic agents or succinylcholine. The fulminant syndrome is characterized by muscle rigidity, fever, tachycardia, tachypnea, increased oxygen consumption, and lactic

Table 2—*Disorders similar to the malignant posttraumatic hypermetabolic syndrome (MPHS)*

	Malignant hyperthermia	*Tetanus*	*Strychnine poisoning*	*Neuroleptic malignant syndrome*	*MPHS*
Clinical					
Rigidity	+	+	+	+	+
Fever	+	+	+	+	+
Diaphoresis	+	+	+	+	+
Tachycardia	+	+	+	+	+
Laboratory					
Elevated CPK +	+	+	+	+	+
Increased VO_2 + +	+	+	ND	+	+
Lactic acidosis	+	+	+	+	−
Complications					
Renal failure	+	+	+	+	+
Hypernatremia	−	+	+	+	+
Orthopedic	−	+	−	−	+
Response to treatment					
Pancuronium	−	+	+	+	+
Diazepam	−	+	+	+	+
Dantrolene	+			+	+
Amantadine				+	
Bromocriptine				+	−

+ = Creatine phosphokinase
+ + = Oxygen consumption
ND = Not done

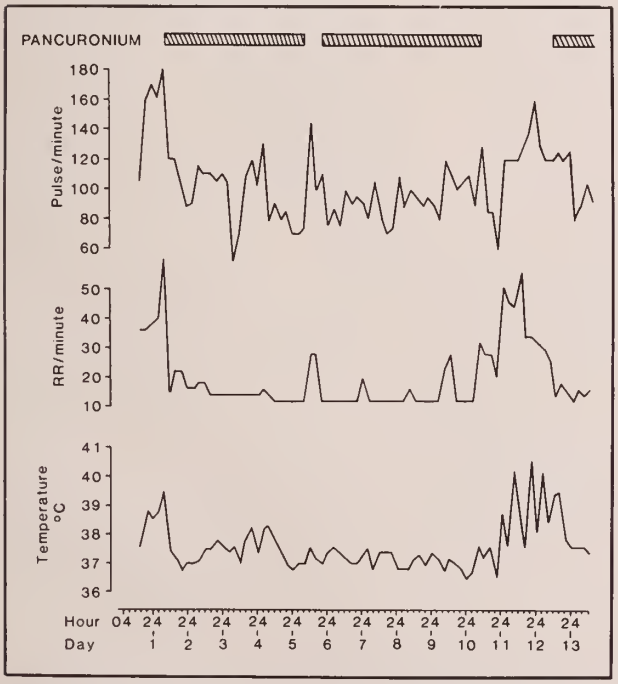

Figure 1—*Serial vital signs in Case 4 demonstrating increased pulse, respirations, and temperature when pancuronium bromide was discontinued. Recurrent posturing and diaphoresis occurred simultaneously.*

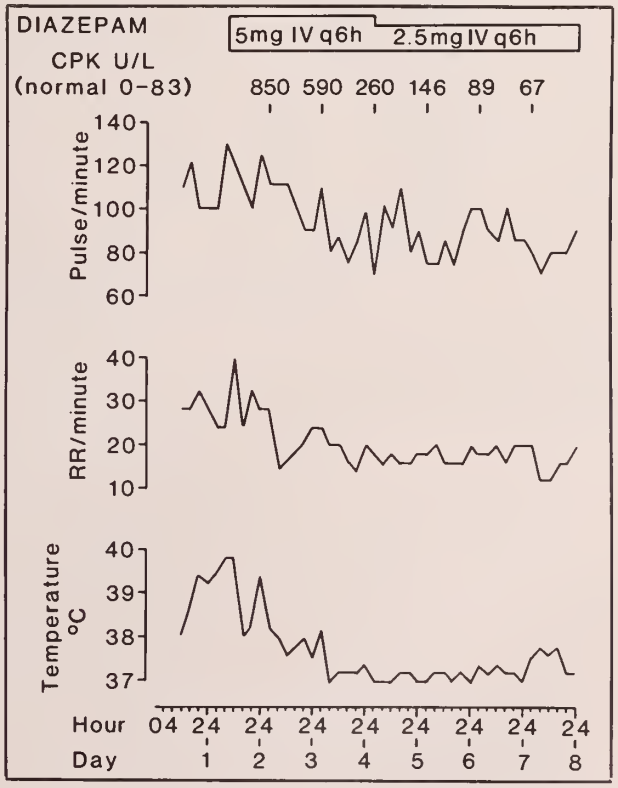

Figure 2—*Serial vital signs and creating phosphokinase (CPK) measurements in Case 6 showing resolution of MPHS and elevated CPK during treatment with diazepam.*

acidosis. Complications may include rhabdomyolysis, hyperkalemia, cardiac arrhythmias, disseminated intravascular coagulation, neurologic disorders, and acute renal failure. The skeletal muscle relaxant, dantrolene, is effective in treatment of the disorder.[6-10]

The clinical manifestations of tetanus are caused by the toxin tetanospasmin which interferes with neuromuscular transmission at the nerve terminal. Autonomic involvement may lead to diaphoresis, fluctuating hypertension, episodic tachycardia and cardiac arrhythmias even during neuromuscular blockade.[11-14] This phenomenon makes comparison to MPHS difficult. The major manifestations of the disease, however, are secondary to severe sustained muscle contracture. Fever, tachycardia, and increased oxygen consumption are consistent features. The increased oxygen consumption decreases after diazepam therapy.[15] Complications of tetanus include: lactic acidosis, rhabdomyolysis, acute renal failure, fractures, and dislocations.[16-20]

Strychnine blocks glycine uptake, disinhibiting the motorneuron. Strychnine poisoning is characterized by powerful extensor muscle spasms, hyperpyrexia, tachycardia, and tachypnea. It is complicated by lactic acidosis, rhabdomyolysis, and acute renal failure. The syndrome is effectively treated with diazepam or pancuronium and respiratory support.[21-23]

The neuroleptic malignant syndrome is a rare idiosyncratic reaction to major tranquilizers. Following drug exposure severe extrapyramidal muscle rigidity is followed by hyperpyrexia, tachycardia, tachypnea, diaphoresis and labile hypertension.[24-26] The syndrome can be effectively treated with centrally acting dopamine agonists (amantadine or bromocriptine) which suggests a pathogenetic role for dopamine receptor blockade.[27-28] Peripherally acting muscle relaxants (dantrolene sodium) are also effective.[29-30] Complications may include rhabdomyolysis and acute renal failure.[31] Although the syndrome is centrally mediated, oxygen consumption decreases after dantrolene therapy.[29] This implies that fever and hypermetabolic state are due to the sustained muscle contracture.

A variety of other clinical circumstances including status epilepticus and phencyclidine intoxication may lead to a similar, but less severe, constellation of symptoms and complications.[32,33] We would suggest that the pathophysiology is similar.

Although beta blocking drugs are effective in blocking the catecholamine-induced hemodynamic alterations following head injury, we would recommend caution using these drugs in patients with MPHS. Bradycardia and vasoconstriction induced by these drugs could interfere with heat dissipation and aggravate hyperthermia. These patients should be treated with diazepam or pancuronium and monitored carefully for complications. Aggressive nutritional support must be emphasized. Our patients lost large amounts of body weight despite receiving greater than 2400 kcalories daily. Since hypermetabolism may be aggravated by large carbohydrate loads, a high protein, high fat enteral formula may be preferable.[34]

MPHS is initiated by severe brain injury leading to intense decorticate or decerebrate posturing. Fever, diaphoresis, flushing, tachycardia, and tachypnea likely represent physiologic responses to excessive heat generation and oxygen consumption from the rigid muscles. Hypothalamic injury and increased catecholamine excretion may contribute to the syndrome by interfering with central heat and hemodynamic regulation. The concept of hypermetabolic complications arising from sustained muscle contracture has significant implications on patient management. This syndrome should be considered in any brain-injured patient with disproportionate or otherwise unexplained fever, tachypnea, and tachycardia. These findings should not always be attributed to nonspecific hypothalamic dysfunction, autonomic nervous system instability, or excessive catecholamine excretion. Therapy with muscle relaxants is specific and effective.

REFERENCES 1-34 available upon request to the authors. ■

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

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1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
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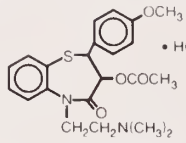
DESCRIPTIDN

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 3D mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 2D mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 24D mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 8D% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 12D mg of CARDIZEM result in detectable plasma levels within 3D to 6D minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 1D% to 2D% of the parent drug and is 25% to 5D% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 5D to 2DD ng/ml. There is a departure from dose-linearity when single doses above 6D mg are given; a 12D-mg dose gave blood levels three times that of the 6D-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIDNS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CDNTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 2D%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.D mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 5D mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 80D ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 3D mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIDNS.)

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Cardizem 30-mg tablets are supplied in bottles of 1DD (NDC DD88-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 1D0 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 1DD (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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Reception brings 800 physicians and 100 legislators together

On October 9 SMS members backed their leadership solidly with a turn-out of more than 800 physicians at a legislative reception in Madison. More than 100 legislators accepted the SMS invitation to join them.

The goal of providing a forum for physicians to acquaint themselves with legislators and express their individual concerns and perspectives on the medical liability issue was more than met, according to the SMS's Physicians Alliance Division director, Brian Jensen.

"The reception was an extremely gratifying outpouring of physician support for the SMS effort to obtain some meaningful reforms," Mr Jensen said. "I was overwhelmed by the sheer numbers of both physicians and legislators who attended. Perhaps it should be done during every legislative session."■

SMS Annual Meeting plans underway

Scheduled for April 17-19, 1986 at MECCA in Milwaukee, the theme for the Annual Meeting is entitled "Cost-Effective Care of the Pediatric Population." The 1986 scientific program committee consists of Kenneth I Gold, MD, Beloit, and Kay Heggestad, MD, Madison.

Tentative panel topics include "Public health consequences of nuclear armaments;" "What's new and important in socioeconomics;" "Pediatric-perinatology;" "Genetics;" "Value of routine check-ups;" "Teenagers;" "Areas of oversell . . . Overtreatment . . . overuse;" "Areas that might be modified due to cost considerations;" and "Areas in which more efforts in prevention might be cheaper than treatment."■

New Communications Coordinator named

Mary A Kane joined the State Medical Society staff September 12 as Communications Coordinator, succeeding Diane Upton who resigned to become a full-time homemaker.

Ms Kane has 10 years' experience as a journalist, seven of them with *The Northwestern,* an Oshkosh daily newspaper. While on *The Northwestern's* staff, Ms Kane was a reporter and chief of the paper's Ripon Bureau which covers Fond du Lac County and the surrounding area.

Ms Kane worked this summer as a part-time, temporary copy editor at *The Wisconsin State Journal.*

Prior to joining *The Northwestern,* she worked on the reporting staffs of *The Ripon Commonwealth Press* and *The Fond du Lac Reporter.*

Ms Kane is a recipient of numerous awards in the annual Wisconsin Press Women Communications Contest, including the 1982 competition in which she was the overall winner, receiving five first place citations.

Prior to moving to Madison, Ms Kane was a Ripon resident for 10 years following her 1974 graduation from Ripon College. She earned a degree in French, with a minor in English.

Ms Kane

While in Ripon, Ms Kane was active in several civic and professional groups, including Wisconsin Press Women in which she held a variety of offices; the League of Women Voters; the American Association of University Women; the Educational Club of Ripon; the Wau-Bun Girl Scout Council's ad hoc nominating committee; the Ripon Child Care Center board of directors, and St Wenceslaus Catholic Church.■

More than 1,000 students, teachers attend SMS Workshop on Health

More than 1,000 students and teachers from 171 high schools around the State attended the October 2 annual Workshop on Health at Oshkosh.

Carol Cassell, PhD of Albuquerque, NM, past president of the American Association of Sex Educators, Counselors, and Therapists, talked about "Love Versus Sex" in a keynote address followed by two series of workshops.

This year's workshop theme was "Awareness is the Answer: Teenage Sexuality/Teenage Pregnancy."

This was the 23rd event of its kind jointly sponsored by the State Medical Society of Wisconsin and its Auxiliary.■

1984 MEMBERSHIP SURVEY

Members want greater emphasis on public image of profession

THE STATE MEDICAL SOCIETY of Wisconsin, in conjuction with the Department of Survey Design and Analysis of the American Medical Association, designed a 1984 survey of SMS members. The purposes of the survey were to assess SMS performance on a number of programs and activities, ascertain the perceptions of members as to their reasons for belonging to the Society, and collect important demographic data from the members. The information obtained is being used by the Task Force on Medical Care, various commissions and committees of SMS, and by the Board of Directors in establishing issue priorities, planning budgets and programs, and developing legislative strategies.

Survey design

Licensed physicians practicing at least part-time who belong to the State Medical Society of Wisconsin received a mail survey in November 1984. Retired physicians and candidate members were not surveyed. By the cutoff date, nearly 60 percent of the 4,588 questionnaires were returned. These 2,641 respondents were representative of the sample on major background variables: major professional activity, specialty, sex, age, and county size. This representativeness was determined by comparison of data available on the computerized AMA Physician Masterfile for the sample.

Physicians' level of involvement in organized medicine

- The majority of respondents consider themselves active in hospital medical staff (88.7%), state (51.5%), county (59.6%), and specialty (61.9%) societies. However, only one-third define themselves as active in the AMA.
- Equal numbers of members of SMS define themselves as inactive members (47.7%) or active members (47.4%). Four percent are active leaders.
- Nearly 9 in 10 SMS members take an active role in hospital medical staff organizations (active leader, 27.7%; active member, 61.0%).
- The largest percentage of active leaders in SMS are in the age categories of 50-54 years of age (8.3%) and 45-49 years of age (6.1%). Approximately half of each age group define themselves as active members of SMS, with the exception of members in their thirties (30-34 years, 39.2%; 35-39 years, 42.6%).
- Active leaders and members rated programs more highly than inactive members. For example, 69 percent of the active members and 59.4 percent of the inactive members rated WISPAC as excellent or good.

Membership priorities

- Three-fourths (75.6%) of the respondents called for greater emphasis on the public image of the profession.
- Seventy percent of the respondents favored greater attention to professional liability and malpractice issues.
- Approximately half of the respondents said more emphasis should be given to the following issues: state/federal government involvement in Wisconsin healthcare (49.8%); relationship with third-party payors (49.6%); and costs of healthcare (49.6%).
- The majority of SMS members (62.5%) describe themselves as somewhat informed about SMS activities. One-fifth (20.1%) are "very well informed."

Readership patterns

- Of the three SMS publications, *Wisconsin Medical Journal, Medigram,* and *Capitol Week, Medigram* is read most regularly. For all three publications, active SMS members are more regular readers than others. Older physicians tend to read *WMJ* and *Medigram* more frequently than younger physicians.
- Almost half (48.0%) of the SMS members read the *Wisconsin Medical Journal* regularly and more than one-third (35.6%) read it occasionally.
- More than two-thirds (69.3%) of the respondents read *Medigram* regularly and an additional 22.5 percent read it occasionally.
- Among the one-third who receive *Capitol Week,* 39.3 percent read it regularly and 32.4 percent read it occasionally.

State Medical Society of Wisconsin Programs

- Representation of medicine's views to legislators and communication of medicine's concerns and accomplishments to the general public were rated as important reasons for membership by more than 90 percent of the respondents.
- Three-fourths of the respondents consider *Medigram* and the *Wisconsin Medical Journal* as important reasons for their membership.
- More than 50 percent of respondents cited exchanging views with other professionals and political candidate support through WISPAC important for their membership decision.
- Peer pressure and direct benefits (*eg,* insurance programs, dis-

count plans) were considered important reasons by fewer than half the members.

- Overall, members gave the highest performance ratings to "communication with the profession (excellent 24.7%; good 58.2%) and to the Society's legislative activity (excellent 23.6%; good 49.1%).

Practice characteristics

- The median number of hours worked per week is 53 hours. Almost two-thirds (60.8%) of the physicians work 46-60 hours per week, and 5.9 percent work more than 70 hours. Physicians in small cities or towns (5,000-25,000 population) work slightly more hours than physicians in other locations.
- Partnership or group practice is the most common type of practice among the respondents. For the period of the last five years, solo practice was the second most common type of practice.
- The most dramatic change is in terms of participation in preferred provider organizations (PPOs). Participation in PPOs is expected to increase from 3.3 percent of the respondents five years ago and 7.9 percent currently, to 13.5 percent during the next five years.
- Participation in health maintenance organizations (HMOs) has increased from 16.0 percent during the past five years to 29.3 percent during the current year. With respect to the next five years, HMO participation is expected to remain constant at 29.2 percent.
- Participation in independent practice associations (IPAs) has increased from 8.2 percent during the past five years to 15.0 percent during the current year. Slightly more than 16 percent of the membership indicated IPA participation in the next five years.
- Participation in freestanding surgery centers and ambulatory care centers is expected to increase. Respondents predicted that the percentage of physicians practicing in hospital outpatient departments and community health centers will decline.
- Of the respondents who stated they have been in solo practice for the past five years, about one-half (55.6%) are only in solo practice today, 2.8 percent are only in group practice and 41.6 percent are in some other practice arrangements (including participation in a group or solo practice along with some other activity.
- Of the respondents specifying only group practice during the *past* five years, two thirds (63.5%) are in a group practice only, 1.7 percent are in solo practice only, and 34.8 percent are in some other arrangements.
- Among respondents currently in solo practice only, 70.3 percent expect to be in solo practice only in the *next* five years. Another 3.0 percent expect to be in group practice only, and 26.7 percent expect to be working in some other arrangement (including participation in a group or solo practice along with some other activity).
- Of those respondents who currently are in group practice only, 0.6 percent expect to be in solo practice only and almost one-quarter (24.4%) expect to be in some other arrangements during the *next* five years.
- Many physicians practicing in HMOs also participate in some other form of medical practice. More than three-quarters (77.2%) specified partnership or group practice also, IPAs were specified by almost one-third (31.8%) of respondents, hospital outpatient departments by 19.1 percent, and PPOs by 18.5 percent. Solo practice was specified by 19.0 percent of the respondents in HMOs.
- The most common practice location is outside of the central business district of a city (31.9%).
- Nearly three-quarters (73.4%) specified that their medical practice is incorporated.
- The average number of physicians in a group practice is 15.

Group, HMO, and IPA physicians

- Among those who have joined an HMO/IPA, more than half (58.0%) first joined during 1983 or 1984 and 13.6 percent joined during 1982.
- Among HMO/IPA physicians, the average number of HMOs/IPAs that they participate in is one. Respondents were more likely to belong to more than one HMO than to more than one IPA.
- Of eight possible factors motivating physicians to join an HMO/IPA, the most frequently checked factors were retention of patients (87.3%), the ability to compete with alternative healthcare systems (83.9%), and increased patient base (64.9%).
- Two-thirds of the HMO/IPA physicians specified that a change in their practice arrangement has not increased or decreased their income. Of the respondents commenting on this question, most specified that it was too early to know the effect on their income.

Compensation

- Over one-third of the physicians derive 100 percent of their compensation from fee-for-service while only 29.7 percent derive none of their income from fee-for-service. Capitation was least likely to be the form of compensation. A salary accounted for 100 percent of the medical practice income of 15.8 percent of the respondents, while 62.9 percent received no salary at all.

- Typically one-quarter of the patient load is reimbursed by Medicare. Responses ranged from 0 to 100 percent.
- The median percent of a patient load reimbursed by Medicaid is 10 percent. Medicaid patient load ranged from 0 to 100 percent.

Importance of healthcare issues in Wisconsin

- When presented with six healthcare issues, 85 to 90 percent of the respondents rated each issue at least somewhat important.
- The ranking of the importance accorded the issues is: cost of healthcare, federal government regulations, state government regulations, the distribution of healthcare providers, the supply of healthcare providers, and the availability/accessibility of care.

Cost of healthcare

- Respondents were almost evenly split between indicating that the cost of healthcare today is too high (45.6%) and that the cost is about right (48.5%).
- Older age groups and those physicians in primary care specialties (family practice, general practice, pediatrics, internal medicine) and in psychiatry appear more concerned about high costs.

Income from medical practice

- Almost two-thirds of the respondents indicated that their annual net taxable income from medical practice and related activities for 1983 was between $50,000 and $125,000 ($50,000-$74,999, 23.4%; $75,000-$99,999, 24.6%; $100,000-$124,999, 15.8%).
- Among those responding, 60.6 percent had net taxable incomes under $100,000.
- Over 71 percent of physicians in rural areas had incomes between $25,000-$100,000. Median income for rural practitioners was $62,500 as opposed to $87,500 for physicians in all other locations.
- Median income, by specialty, ranged from $62,500 for family practice/general practice, pediatrics, and psychiatry to $137,500 for radiology.
- Male physicians overall earned $25,000 to $30,000 more than female practitioners.
- Median net taxable income of all member physicians in 1983 was $87,500.■

NOTE: The mean income is the sum of the incomes divided by the total number of physicians reporting an income. The median income is the middle income; if the incomes were ranked, half would be above the median and half would be below the median. Generally, incomes are not evenly distributed, with a few extremely high incomes. The mean, which as a balance point is sensitive to extreme cases, will be high, but the median—always the middle—will be lower and therefore more typical of the entire distribution. Thus, although one often thinks of the mean as the average, the median is the preferred measure of average income.

Membership encouraged for residents and students

The State Medical Society of Wisconsin is encouraging medical students and resident physicians to join organized medicine early in their careers.

Dues are waived for freshman medical students while upper classmen and postgraduate ones pay only $10.00. Resident physician membership dues for 1986 are $45.50, just 10 percent of regular dues.

Physicians elected to SMS membership within six months of completing residency, fellowship, or fulfillment of government obligation enjoy a dues reduction of 50 percent for the first year and 25 percent the second year.

The AMA has a very low dues structure for the Student Member and Resident Member as well. In addition, to attract new members the AMA has a reduction of dues for the new practitioner of 50 percent for the first year and 25 percent the second year.

Physicians are urged to seriously consider joining organized medicine as early as possible to take advantage of these special membership rates.

To begin the membership process, if your practice is or will be located in Wisconsin, or if you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society: 1-800-362-9080 (Madison area number: 257-6781.)

■

Dues payment options available

State Medical Society members have several options when paying membership dues in organized medicine. These programs are designed to provide SMS members with a plan most convenient for them.

Members classified as "regular," "part-time practice," and "over age 70" may take advantage of the installment payment option. This plan allows members to pay one-half of the total dues amount prior to January 1, with the balance due on or before May 15. Members should note that they will continue to receive

continued on next page

Continued from preceding page
monthly statements indicating the outstanding balance.

New members should be aware that AMA publications which they will receive as an *AMA member* will be sent only after the full AMA dues are received by the Association.

A second option allows members to pay dues using their Mastercard or VISA credit cards. The membership dues statement will include an easy-to-use form if members select the credit card plan.

Of course, members may opt to pay their dues by check in one lump sum. This method avoids any delays in receiving publications and other "tangible" benefits. As with the options listed above, SMS collects county society and AMA dues and distributes them to the appropriate organization.

If you have any questions regarding these payment alternatives, please contact the State Medical Society toll-free 1-800-362-9080.■

Reduced Practice or Retired membership classifications

The State Medical Society reminds physicians who have reduced their practice to 1,000 hours or less during the calendar year, but do not qualify for Retired status, that they may apply for a "Part-time Practice" classification which waives 50 percent of the regular membership dues.

Physicians who have reached age 70, but are still practicing, qualify for "Over Age 70" classification, and receive a 50 percent reduction of regular SMS dues as well.

These special membership classifications must be applied for through the physician's county or state society. The changes will become effective January 1 following approval or the year after the physician reaches the age of 70 and cannot be made retroactive.

Other classifications which may be requested for which dues exemptions may apply are:

Associate: Financial hardship due to illness or disability
Retired: Works less than 240 hours per year
Military Service: Temporary service in the Armed Forces or National Health Service

Some county societies and the AMA have reduced or waived dues for the same classifications as SMS. Physicians who are retired or will be retiring should advise their county or state society of their present or future status so that a change in classifications can be arranged.■

Spouse physicians take note

Did you know that two-physician families are eligible for dues reduction in SMS membership?

Under a plan approved by the SMS Board of Directors, one member of two-physician families is entitled to a dues break of $50. The other member pays full dues. The members themselves would identify which one receives the discounted rate.

The Society requests that such two-physician families use the home address for mailings so as to assure equal access to the Society's communications. The reduction of dues is supported by eliminating duplication of Society mailings, including the *Wisconsin Medical Journal* and *Medigram.*

Spouse physicians are urged to identify themselves as two-physician families and request the dues reduction of $50 for one member of the family.■

Wisconsin Association of Senior Physicians met November 9

Members of the Wisconsin Association of Senior Physicians met Saturday, November 9 at the Madison Club in Madison with Kenneth Carter, MD, Beloit, presiding president.

The major topic for discussion was *Estate Planning: The New Wisconsin Marital Property Reform Law,* which was presented by Robert Webster, assistant vice-president of the First Wisconsin National Bank Trust Department, Madison.

A report on the Charitable, Educational and Scientific Foundation of the State Medical Society, *What It Is and Who Needs It,* was presented along with a slide show.

SMS President John K Scott, MD, addressed the group on *Medicine: 1985 and Beyond.*

A Norwegian travelogue, *Land of the Midnight Sun,* was presented by Eugene J Nordby, MD of Madison.

A short business meeting with election of officers was held. Election results will appear in the December issue.■

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Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1986 are $455 for SMS, $375 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. • ***First year in practice***—physicians elected to SMS membership within six months of completing residency, fellowship, or fulfillment of government obligation enjoy a dues reduction of 50 percent for the first year. • ***Second year in practice***—physicians who quality by meeting the above criteria enjoy a 25 percent dues reduction during their second year of practice. • ***Two-physician family***—one member (spouse) of a two-physician family is entitled to a dues reduction of $50 or the amount of their State Society dues whichever is less.

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1986 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455.00	$375.00	Normal County Dues
1st Year in Practice	$227.50	$187.00	Normal County Dues
2nd Year in Practice	$341.25	$281.00	Normal County Dues
Two Physician Family	$405.00	$375.00	Normal County Dues
Part-Time Practice	$227.50	$375.00/-0-*	Normal County Dues
Part-Time—Over Age 70	$227.50	$187.00*	Normal County Dues
Resident	$ 45.50	$ 45.00	Varies
Military Service	-0-	$250.00/$ 45.00	-0-
Associate	-0-	-0-	-0-
Retired	-0-	$375.00/-0-*	-0-
Retired—Over Age 70	-0-	-0-	-0-
Life	-0-	$375.00/-0-*	-0-
Honorary	-0-	$375.00/-0-*	-0-
Over Age 70	$227.50	$375.00/-0-*	Normal County Dues
Candidate—			
Freshman Year Medical Student	-0-	$ 20.00	Varies
Sophomore and Succeeding Medical Student Years	$ 10.00	$ 20.00	Varies
Postgraduate—One	$ 10.00	$ 45.00	Varies
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-

*Physicians in these categories may be eligible for exemption from paying AMA dues under the grandfather clause.

AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria, with the exception of financial hardship or disability, will automatically be dues-exempt in 1986 and beyond under the grandfather clause.

Under new AMA policy, only the following two categories of physicians will qualify for new dues exemption:

(1) Financial hardship and/or disability.
(2) 70 years of age or older *and* fully retired

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

Your membership in organized medicine will help insure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1986 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

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Cure of the disease is still out of reach. In as devastating a condition as this, even the most modest relief of symptoms—or for that matter keeping them from getting worse or merely slowing their intensification—is a great contribution to patient and family.

HYDERGINE® LC (ergoloid mesylates) is indicated for patients over age sixty who manifest signs and symptoms of idiopathic mental decline. It appears that individuals who respond to HYDERGINE LC therapy are those who would be considered to suffer from some ill-defined process related to aging or to suffer from some underlying condition such as Alzheimer's dementia.

Before prescribing HYDERGINE therapy, the possibility that the patient's signs and symptoms arise from a potentially reversible and treatable condition should be excluded. In addition, because the presenting clinical picture may evolve to suggest an alternative treatment, the decision to use HYDERGINE therapy should be continually reviewed.

HYDERGINE® LC
(ergoloid mesylates)
liquid capsules, 1 mg

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For Brief Summary, please see following page.

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Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (i.e., cognitive and interpersonal skills, mood, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying dementing condition, such as primary progressive dementia, Alzheimer's dementia, senile onset, or multi-infarct dementia. Before prescribing HYDERGINE® (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible and treatable condition, particularly delirium and dementiform illness secondary to systemic disease, primary neurological disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see Contraindications).

Use of HYDERGINE therapy should be continually reviewed, since presenting clinical picture may evolve to allow specific diagnosis and specific alternative treatment, and to determine whether any initial benefit persists. Modest but statistically significant changes observed at the end of twelve weeks of therapy include: mental alertness, confusion, recent memory, orientation, emotional lability, self-care, depression, anxiety/fears, cooperation, sociability, appetite, dizziness, fatigue, bothersome(ness), and overall impression of clinical status.

Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: HYDERGINE LC (liquid capsules); 1 mg, oblong, off-white, branded "HYDERGINE LC 1 mg" on one side, "Ⓢ" other side. Packages of 100 and 500. (Encapsulated by R. P. Scherer, N.A., Clearwater, Florida 33518).

HYDERGINE (ergoloid mesylates) tablets (for oral use); 1 mg, round, white, embossed "HYDERGINE 1" on one side, "Ⓢ" other side. Packages of 100 and 500.

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Also available: HYDERGINE sublingual tablets; 1 mg, oval, white, embossed "HYDERGINE" on one side, "78-77" other side. Packages of 100 and 1000. 0.5 mg, round, white, embossed "HYDERGINE 0.5" on one side, "Ⓢ" other side. Packages of 100 and 1000.

HYDERGINE liquid; 1 mg/ml. Bottles of 100 mg with an accompanying dropper graduated to deliver 1 mg. [HYD—ZZ24—6 15 84]

Before prescribing, see package circular for full product information. HYD-1085-13

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Practice management workshops

The AMA's Department of Practice Management is planning 1986 workshops for physicians and medical office staff in approximately 50 different locations throughout the country. This expansion of the Department's efforts will bring AMA workshops to many more physicians than in the past. Final schedules for January through June 1986 will be available soon. For further information contact Suzanne Fraker, Director, Dept of Practice Management, AMA Headquarters, Chicago. The telephone number is (312) 645-4792.■

U.S. Postal Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION of the *Wisconsin Medical Journal*, issued monthly.

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THE PURPOSE, FUNCTION, AND NONPROFIT STATUS OF THIS ORGANIZATION AND THE EXEMPT STATUS FOR FEDERAL INCOME TAX PURPOSES have not changed during the preceding 12 months.

EXTENT AND NATURE OF CIRCULATION

	AVERAGE NUMBER COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NUMBER OF COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
Total number copies printed (net press run)	6304	6300
Paid circulation (mail subscriptions)	6148	6165
Total paid circulation	6148	6165
Free distribution by mail, carrier or other means (samples, complimentary, and other free copies)	80	35
Total distribution	6248	6200
Office use, left-over, unaccounted spoiled after printing	56	100
TOTAL	6304	6300

I certify that the statements made by me are correct and complete.
/s/ MARY ANGELL
Managing Editor

Date of filing: Sept 27, 1985
PS Form 3526, modified above for purposes of printing.

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Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1985 Membership Directory as published in the July 1985 issue of the *Wisconsin Medical Journal*. Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership records. County transfers will be included when processing has been completed by the Membership Department.

Changes in practice specialties (as used by the AMA) and changes in **Board-certified specialties** as listed by the American Board of Medical Specialties.

(changes only with member's name; practice specialties appear before the slash (/) and Board-certified specialties appear after the slash.)

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J-5491 June 1985

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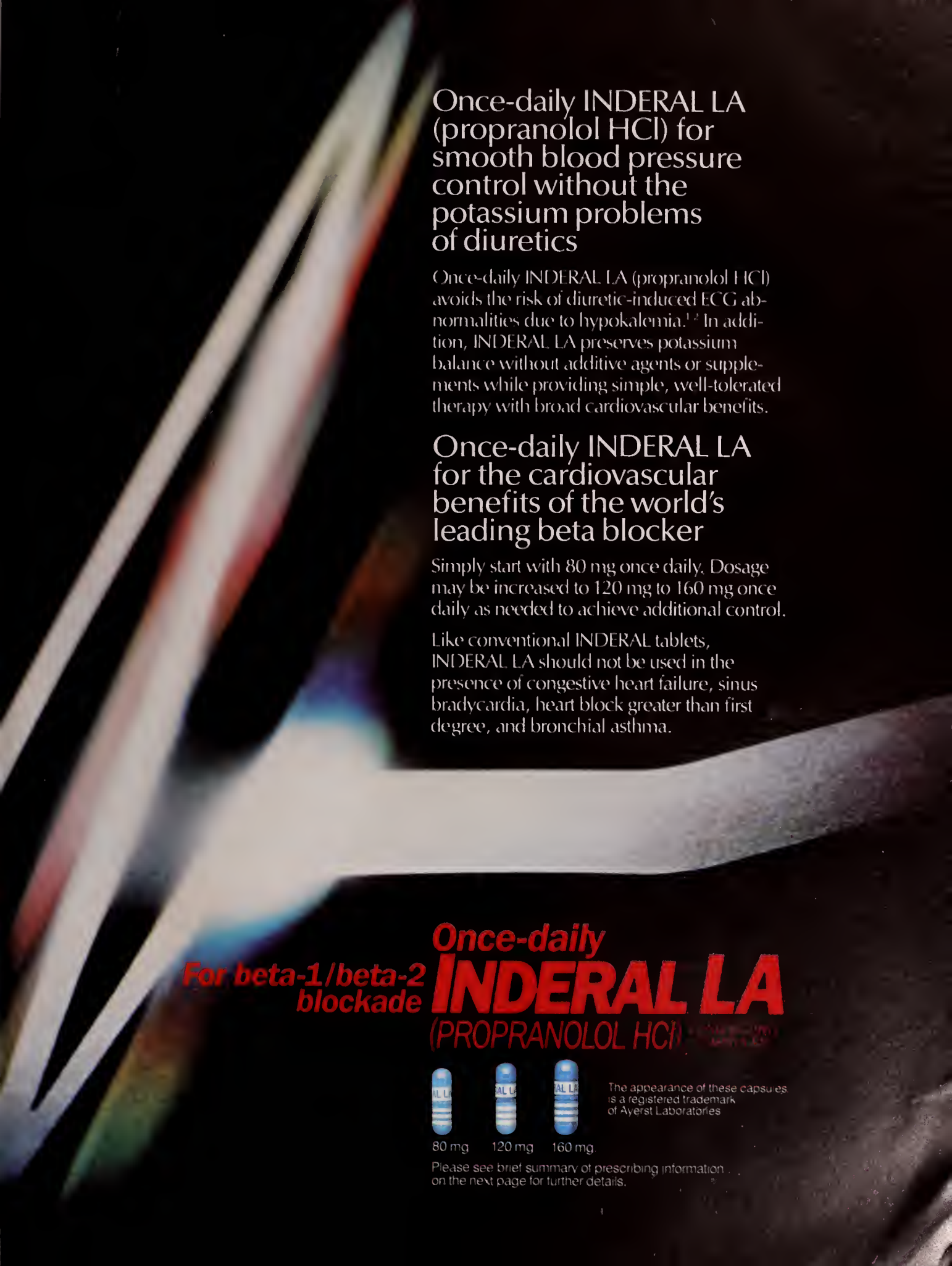

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Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily INDERAL LA (PROPRANOLOL HCl)

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of symoathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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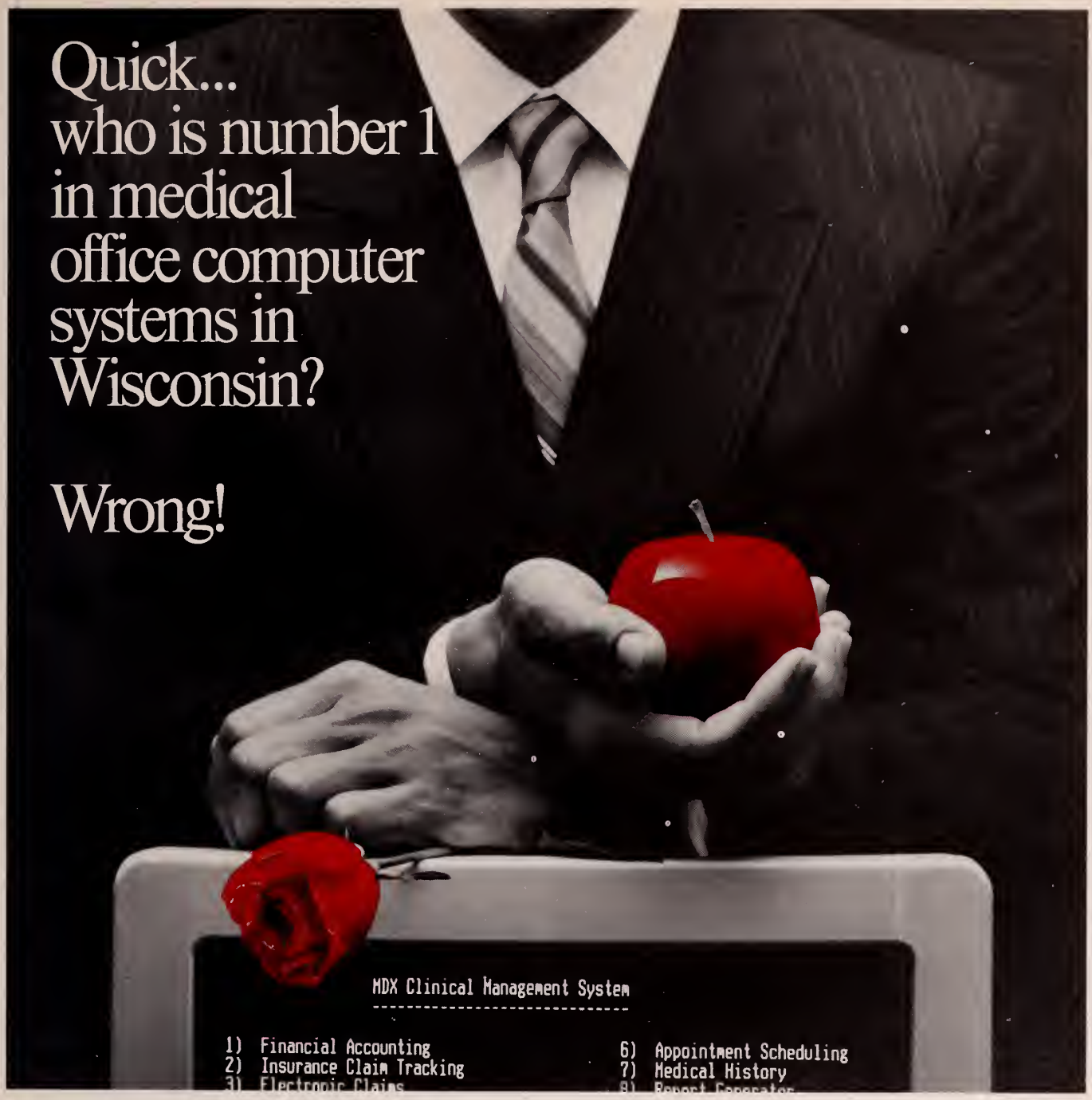

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SMS Liability Task Force chairman testifies

The State Medical Society was well-represented October 2 by Dr William J Listwan, West Bend, in his testimony before the state Senate's Committee on Labor, Business, Veterans Affairs, and Insurance.

As chairman of the SMS Task Force on Medical Liability, Doctor Listwan spoke in support of those elements of Senate Bill 328 which would:

—help stabilize medical malpractice premiums and reduce the Patients Compensation Fund deficit;

—provide for a wider range of sanctions against physicians found negligent;

—strengthen peer review and the Medical Examining Board's role; and

—allow institution of surcharges on insurance premiums for those physicians who have claims paid on their behalf.

Doctor Listwan's testimony urged a $1 million cap on nonmedical components of awards and unlimited payments on medical damages which are outlined comprehensively in SB 328.

Joining Doctor Listwan in support of SB 328 were:

—Frank Thatcher, a member of the Fund board of governors who served on the Legislative Council's special subcommittee which drafted SB 328;

—Gladys Voegtli of Senior Healthcare, a consumer advocacy group;

—Mari Nahn, an attorney on the staff of the Wisconsin Hospital Association;

—Thomas Fox, state insurance commissioner;

—Bill Klouthis, Wisconsin Rapids, a representative of the Wisconsin Association of Manufacturers and Commerce's (WMC) task force on healthcare cost containment; and

—Fred Shaffer, WMC's legislative counsel.

Testifying against the bill were representatives of the Wisconsin Academy of Trial Lawyers and some of its members' selected clients.

SB 328 is expected to work its way through the legislative process to the Governor's desk for enactment March 26, 1986. Further information on SB 328 can be found in the President's Page elsewhere in this issue.■

SPOTLIGHT ON SB 328

Ten statewide press conferences in two days

Medical malpractice from the physician's perspective was the focus of 10 press conferences around the state September 25–26.

The tour was part of SMS's continuing REACH program. SMS President Dr John K Scott and SMS Task Force on Medical Liability Chairman Dr William J Listwan met with more than 40 reporters in the series of conferences held largely at airports to ensure maximum coverage in the allotted time.

The press conferences were scheduled to take place exactly one week before state Senate Bill 328 goes to hearing before the Senate's Labor, Business, Veterans Affairs and Insurance Committee chaired by Jerome Van Sistine (D-Green Bay).

The emphasis in each meeting with reporters was on the SMS's proposed amendments to SB 328, specifically that seeking to place a $1 million cap on "nonmedical" expense portions of the total amount awarded in a case.

As Doctor Listwan and Doctor Scott stressed, the purpose of the SMS proposal is "to pay the medical expenses of an injured person and to care for that individual in the future" while at the same time preserving the basic intent of the Patients Compensation Fund.

Yet, without fail, at each press conference location, at least one journalist inquired as to whether the malpractice issue isn't simply one of "the doctors versus the lawyers."

SMS representatives were aware the Wisconsin Academy of Trial Lawyers had its own response to SB 328 in which, incidentally, it agrees the draft legislation's proposed absolute cap of $3.3 million on all awards should be dropped. It is clear, Doctor Listwan told reporters, that it is principally the trial lawyers who stand to lose the most should any cap be placed on awards; but the SMS proposal would ensure a patient suffering medical losses would be compensated to whatever extent required.

Two other themes running consistently throughout the questioning in all 10 cities were:

—What about the "bad doctor": should the profession be more

continued on next page

Continued from preceding page

aggressive in its self-policing measures?

—And, what kinds of cutbacks in insurance costs can the average individual expect if the SMS proposal is enacted into law?

In response, the SMS said:

—There is no denying that both the peer review system and the Medical Examining Board need to be strengthened. The SMS fully endorses the components of SB 328 which deal with tougher sanctions on doctors.

—If caps are placed on malpractice awards, physicians and the public alike cannot expect to see anything more than a holding of the line on healthcare or malpractice insurance premium costs as a direct result.

Several reporters expressed interest in writing or broadcasting additional series, features or editorials on the medical liability issue. To assist them, the SMS has prepared a list of physician contacts for reporters seeking to interview members of the profession to "localize" the subject.

SMS will continue to work with the media statewide to educate and inform legislators and the public about the need for reform in the medical liability arena.■

Medicare participating physician program clarified

Due to the considerable confusion that still exists concerning physician reimbursement under the Medicare program, HCFA plans to send a letter of clarification to all physicians serving Medicare patients as soon as possible. Under the Emergency Extension Act of 1985, the existing Medicare fee and reimbursement freeze will continue for at least 45 days, through November 14.

The following points may clarify physicians' particular concerns:

- Physicians who participated 10/84-9/85 and are participating this year may increase their actual charges but, at least during this extension, their Medicare reimbursement levels will remain frozen.
- Physicians who participated 10/84-9/85 and have opted out of the program as of 10/1/85 (they are now "non-participating") must roll back their charges to the levels that were in effect during the April/May/June quarter of the 1984 base period.

NOTE: Physicians who fall into this category are strongly urged to request in writing, by registered mail from WPS, a complete record of their charge levels in effect during the April-June 30, 1984 base period. Following this record of charges from 15-18 months ago will serve to avoid inadvertent violations of the freeze.

- Physicians who did not participate from 10/84-9/85 and remain non-participating as of 10/1/85, must keep their fees to Medicare patients frozen as they have been since the inception of the program. This means that their charges must be held to the base period levels, April 1-June 30, 1984.
- Physicians who did not participate from 10/84-9/85 but who have elected to participate as of 10/1/85, may increase their charges to Medicare patients. They will not be held to the April 1-June 30, 1984 charge levels *but* they must accept assignment on 100% of their Medicare patients.

For those non-participating physicians who raised their fees on October 1, 1985 before knowing the freeze extension, they must return to the fee levels that were in effect 10/84-9/85. (It is still unclear at this writing if HCFA will create penalties for any increased fees during the early days of October or if they will overlook this because of the late actions of Congress and subsequent tardy information sent to physicians on this topic.)

Physicians are also reminded that it is still very likely that Congress may provide an opportunity later in the year to change their participating status for the period ending September 30, 1986.

For more information contact the Physicians Alliance Division at SMS Headquarters in Madison: 1-800-362-9080 toll-free or (608) 257-6781.■

Medical malpractice conference tapes

Requests for the audio cassette tapes of the May 10-11 Medical Malpractice Conference are being processed as rapidly as possible, with about a three-week waiting period.

Because of the overwhelming response for these tapes members who receive the tapes are asked to make every effort to return them to SMS as soon as possible. Requests are being handled on a first-come, first-served basis.

Requests should be directed to the SMS Physicians Alliance Division: 1-800-362-9080 or Madison 257-6781 (ext 162).

BLUE BOOK UPDATE

On page 113 of the June BLUE BOOK issue, the following changes under Corporate Members Representing Component County Medical Societies of the Charitable, Educational and Scientific Foundation should be made.

Calumet: William E Hannon MD—1988
Clark: Vangalla J Reddy MD—1987
Fond du Lac: William G Sybesma, MD—1987
Forest: Burton Rathert MD—1988
Green Lake-Waushara: Barry L Rogers, MD—1987
Lincoln: James Bigalow MD—1987
Monroe: Carlos A Jaramillo MD—1987
Racine: Dennis J Kontra MD—1988
Rock: Arthur C Plautz Jr MD—1986
Rusk: Joseph Bachir MD—1988

On page 123 under the Committee on Environmental and Occupational Health, the subgroup-Ad Hoc Committee on the Public Health Consequences of Nuclear Armaments is composed of:

Susan M Wester, MD, La Crosse
Marc Hensen, MD, Madison
Ben R Lawton, MD, Marshfield
Melvin S Blumenthal, MD, Monroe
Allen Meyer, MD, Eau Claire
William A Morgan, MD, La Crosse
Jeffrey Patterson, DO, Madison

On page 121 under the Section Representatives of the Physicians Alliance Commission, the following appointments have been made.

Allergy Section: **Robert J Kriz, MD,** Madison
Dermatology Section: **Kenneth J Pechman, MD,** Racine
Emergency Medicine Section: **Mark Olsky, MD,** Madison
Internal Medicine Section (2nd representative): **Robert W Ninneman, MD,** West Bend
Neurology Section: **Gamber F Tegtmeyer, MD,** Madison
Preventive Medicine Section: **Constantine Panagis, MD,** Milwaukee

On pp 132 and 133 change Raymond Zastrow's address to 2400 West Villard Ave.■

PUBLIC HEALTH

National Institutes on Health Consensus Development Conference Statement

(Summary and conclusions)

Traveler's Diarrhea

Diarrhea is the major health problem in travelers to developing countries. Travel to high-risk areas in Latin America, Africa, the Middle East, and Asia is associated with diarrhea rates of 20 to 50 percent. The syndrome is caused by an infection acquired by ingesting fecally contaminated food or beverages. *Escherichia coli,* a common species of enteric bacteria, is the leading pathogen, although a host of other bacteria, viruses, and protozoa have been implicated in some cases.

Prudent dietary and hygienic practices should be followed, and they will prevent some, but not all, diarrhea. Antimicrobial agents are not recommended for prevention of TD. Such widespread usage in millions of travelers would cause many side effects, including some severe ones, while preventing a disease that has had no reported mortality. Instead of universal antimicrobial prophylaxis, a more sensible approach is rapid institution of effective treatment that can shorten the disease to 30 hours or less in most people. For mild diarrhea, an antimotility drug such as diphenoxylate or loperamide could be taken. Alternatively, bismuth subsalicylate, which works somewhat slower, can be used. For more severe diarrhea, an antimicrobial drug may be used for treatment, and trimethoprim / sulfamethoxazole, trimethoprim alone, and doxycycline are among the choices. These drugs could be carried by the traveler for use in the event of illness. Oral rehydration should be instituted when necessary.

The millions of Americans who travel annually to developing countries and their physicians must be warned of the potential risks of prophylactic antimicrobial drugs, with the attendant side effects in otherwise healthy individuals, and should be informed of the alternative method of prompt, effective treatment for diarrhea.

Free single copies of the consensus statement on travelers' diarrhea are available from:

Michael J Bernstein
Office of Medical Applications of Research
National Institutes of Health
Building 1, Room 216
Bethesda, Maryland 20205■

WOMEN IN MEDICINE Project has compiled a resource packet on the work patterns, practice characteristics, and income of female physicians. Copies of the 63-page document, titled 'In the Marketplace,' are available from Women in Medicine Project, AMA headquarters, Chicago. The telephone number is (312) 645-4391.■

James Ostiguy, MD, Appleton, has joined the medical staff of the Carenow Convenience Clinic. Doctor Ostiguy graduated from the University of Massachusetts Medical School and completed his internship and residency at St Francis Medical Center in Peoria, Ill.

James E Burwitz, MD,* recently became associated with the Carenow Convenience Clinic in Appleton. Doctor Burwitz graduated from the University of Wisconsin Medical School, Madison, and served his family practice residency at the University of Wisconsin-Wausau program. He previously practiced in the New Lisbon Community Clinic.

Rolf Poser, MD, Columbus, a member of the Poser Clinic, recently had a research paper published in the *American Heart Journal.* The article entitled "Aggravation of Arrhythmia Induced with Antiarrhythmic Drugs during Electrophysiologic Testing" is about commonly used heart medications which suppress extra and sometimes dangerous heart beats.

Barry B Edelstein, MD, Marshfield, has joined the Department of Radiology at the Marshfield Clinic. Doctor Edelstein graduated from the State University of New York-Downstate Medical Center in Brooklyn. He served his internship at the University of Chicago Hospital where he also completed his residency in radiology. Doctor Edelstein previously had been in private practice in Chicago.

James B Unger, MD,* recently became associated with the Marshfield Clinic. Doctor Unger, who had previously served on the medical staff of the Clinic, graduated from the University of Illinois Abraham Lincoln School of Medicine in Chicago. His residency in obstetrics and gynecology was completed at the University of Mississippi in Jackson. Doctor Unger previously had practiced at the Carbondale Clinic in Illinois.

Dennis D Ohlrogge, MD,* Holmen, has joined the medical staff of the Skemp-Grandview Holmen Clinic in Holmen. Doctor Ohlrogge graduated from the University of Minnesota School of Medicine and completed his residency at St Mary's Hospital in Milwaukee. He practiced from 1982-1985 in Nome, Alaska.

David A Onsrud, DO,* has joined the medical staff of the Skemp-Grandview Clinic, La Crosse. Doctor Onsrud graduated from the College of Osteopathic Medicine and Surgery, Des Moines, Iowa. He completed his residency at Good Samaritan Hospital, Milwaukee.

James Deming, MD, recently became associated with the Skemp-Grandview's Lake Tomah Clinic. Doctor Deming graduated from the University of Wisconsin Medical School and completed his family practice residency at the Cedar Rapids, Iowa Medical Education Program.

Robert E Phillips, MD,* Marshfield, medical director of Bethel Living Center in Arpin, has been chosen Physician of the Year by the Wisconsin Association of Nursing Homes. For the past five years, Doctor Phillips has been the attending physician at Bethel and for two and one-half years, he has been medical director and primary physician for Bethel residents. Doctor Phillips also is a member of the medical staff at the Marshfield Clinic.

Jim Le Claire, MD, Washburn, recently became associated with the Bayfield County Hospital and Clinic. Doctor Le Claire graduated from the Mayo Medical School, Rochester, Minn, and served his internship at St Joseph's Hospital, Milwaukee. His residency was completed at the University of Wisconsin, Madison.

Michael Woods, MD, Brookfield, has been chosen one of the 10 Healthy American Fitness Leaders for 1985. Doctor Woods, who was a speed skating competitor in the 1984 Olympics, was chosen for the time and talent he has donated while serving as vice president of the Wisconsin Olympic Ice Rink Foundation.

Randall J Casper, MD, recently became associated with the Midelfort Clinic in Eau Claire. Doctor Casper graduated from the University of Minnesota School of Medicine and served his residency at Hennepin County Medical Center in Minneapolis. He is in the Department of Internal Medicine.

Edward P Horvath, Jr, MD,* Marshfield, recently resigned his position in the Department of Occupational Medicine at the Marshfield Clinic to accept the position as Corporate Director of Occupational Health for Standard Oil Company in Cleveland, Ohio. Doctor Horvath was a member of the Committee on Environmental and Occupational Health of the State Medical Society.

James O Redmann, MD, has joined the Department of Ophthalmology at the Midelfort Clinic in Eau Claire. Doctor Redmann graduated and also served his residency at the Medical College of Wisconsin in Milwaukee.

Richard Lucas, MD, has joined the Department of Psychiatry at the Midelfort Clinic, Eau Claire. Doctor Lucas graduated from the University of Pennsylvania School of Medicine and completed his residency at the University of California.

Michael R Diestelmeier, MD, recently became associated with the Midelfort Clinic in Eau Claire. Doctor Diestelmeier graduated from the University of Iowa Medical School and completed his internship and residency, in dermatology, at Walter Reed Army Medical Center, Washington, DC.

Thomas J Murphy, MD, recently joined the Grafton Clinic. Doctor Murphy graduated from St Louis University School of Medicine and completed his residency at the Tufts University Medical School Affiliated Hospitals in Springfield, Mass, and the Yale University Affiliated Hospital, New Haven, Conn. From 1980-82, Doctor Murphy served in the United States Public Health Service Corps.

Carrie Ware, MD, has joined the medical staff of the Artwich Clinic in Oconto Falls. She graduated from the Oregon Health Sciences University, Portland, and completed her residency at Oregon Health Sciences University and the Portland Veterans Administration Hospital.■

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The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of September 1985.

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WORK WEEK OF HEALTH

State Medical Society of Wisconsin

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

AUGUST

* Arndt, George W, Neenah
* Beckes, Robert J, Wauwatosa
* Berridge, Frank E, Milwaukee
* Bhore, Jayawant N, Milwaukee
Boehme, Larry R, Hillsboro
Cullen, Gerald M, Milwaukee
* Davila, Julio C, Wausau
* Dernlan, Robert L, Manitowoc
* Doyle, Thomas J, Eau Claire
* Fink, Richard A, La Crosse
* Frechette, Paul F, Janesville
* Geist, Jack E, Milwaukee
* Goren, Carolyn, La Crosse
* Gromer, Rex C, Neenah
* Hankey, Terry L, Wausau
Heckman, Margaret G, Wood
* Ibach, Harold F, Milwaukee
* Logan, Richard, Middleton
Lorenzen, Kraig E, Brookfield
Manning, Dennis P, Milwaukee
* Martens, William E, Wauwatosa
* Matzke, Robert F, Janesville
* Meeter, Urquhart L, Medford
* Mockert, Thomas, Sheboygan
* Nair, Velayudhan K, Monroe
* Przlomski, Andrew T, Kenosha
* Quackenbush, Steven R, Woodruff
Rahko, Peter S, Madison
Remeniuk, Eudokia, New Berlin
* Rose, Quentin F, Milwaukee
* Sneed, Robert J, Ashland
* Stewart, Richard D, Racine
Sullivan, Richard L, Milwaukee
* Tang, Thomas T, Milwaukee
* Toohill, Robert J, Milwaukee
* Travelli, Renato, La Crosse
Urtes, Mary-Ann, Madison
* Wex, Thomas E, West Bend
* Witt, Raymond W, Kenosha

SEPTEMBER 1985

Becker, Robert C, Milwaukee
*Betlach, Eugene H, Janesville
*Cohen, Steven H, Milwaukee
*Cooke, William T, Richland Center
*De Kraay, Warren H, Kenosha
*Diba, Ali-Akbar, Milwaukee
*Drury, Colin J, New Richmond
*Erchul, James W, Appleton
Frazier, Harold N, Milwaukee
Geissler, Mark S, Madison
*Kjentvet, Roger A, Wild Rose
*Knauf, James W, Chilton
*Lamont, Frederick J, Green Bay
*Lang, Gordon E, Milwaukee
*Laufenburg, Herbert F, Cedarburg
*Mc Wey, Patrick J, Wauwatosa
*Schulgit, Ronald E, Cudahy
*Wilkins, Terrence J, Milwaukee
*Wright, Warren K, Chippewa Falls■

*Members of the State Medical Society of Wisconsin

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2.
Charles Sitkiewitz, District Manager
SMS Services, Inc
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or 800/362-9080

3.
Don F Jabas Associates, Inc
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Manson Insurance
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Orth-Abbott Insurance Service, Inc
6939 Mariner Drive
Racine, WI 53406
414/886-9555

5.
John P Braun Agency
625 57th Street, #800
Kenosha, WI 53140
414/657-3193

6.
Weber Insurance Agency
929 Michigan Avenue
Sheboygan, WI 53081
414/452-3521

7.
American Insurance Services, Ltd
PO Box 247
615 Barstow Street
Eau Claire, WI 54702
715/839-8004

8.
Bead le-Ewing Insurance
6th and State
La Crosse, WI 54601
608/784-4854

9.
Donald F Peterson, Manager
Service Programs
SMS Services, Inc
PO Box 1109
Madison, WI 53701
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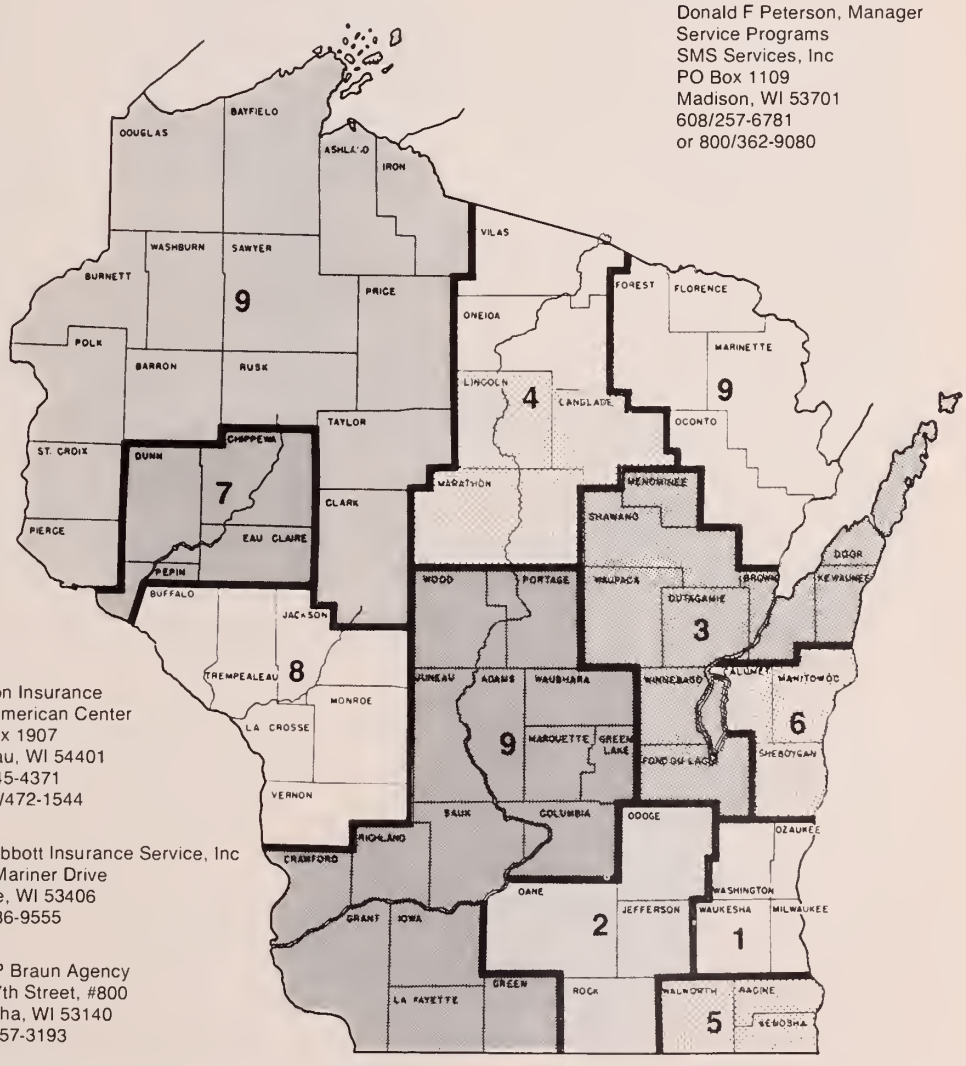

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American Congress of Rehabilitation Medicine has elected John L Melvin, MD,* Milwaukee, as its first vice president at the recent 62nd Annual Session. Doctor Melvin graduated from Ohio State University and currently serves as professor and chairman of the Department of Physical Medicine and Rehabilitation at the Medical College of Wisconsin, Milwaukee. He has been a member of ACRM since 1966 and was elected to its Board of Governors in 1980. He will become president of ACRM in 1987.

American College of Radiology recently elected James J Sherry, MD,* Milwaukee, a fellow of the College. Doctor Sherry graduated from the University of Cincinnati College of Medicine and is presently on the medical staff of Columbia Hospital in Milwaukee. He was selected for this honor for his outstanding work in the field of medical radiology.

American College of Physicians has announced that Philip J Dahlberg, MD,* La Crosse, was elected to fellowship in the ACP. A 1972 graduate of the University of Iowa College of Medicine, Doctor Dahlberg is associated with the Gundersen Clinic Ltd and the La Crosse Lutheran Hospital. He will be honored at the College's Annual Session in San Francisco in April 1986.

Wisconsin Society of Internal Medicine at the 30th Annual Meeting held at Oshkosh, installed James R Mattson, MD,* Green Bay, as president. He succeeds Anthony P Ziebert, MD* of Milwaukee. Other officers include Charles S Geiger, MD,* president-elect, West Bend, and Cyril M Hetsko, MD,* secretary-treasurer.

Doctor Mattson was elected to the WSIM Council in 1980 and served as secretary-treasurer during 1983-84. Doctor Geiger was elected to the WSIM Council in 1980 and has served as secretary-treasurer since 1984. Doctor Hetsko was elected to the WSIM Council in 1981.

Susan L Turner, MD,* Marshfield; Les Harrison, MD, Chippewa Falls; and James L Algiers, MD,* Hartford, were all elected to three-year terms on the WSIM Governing Council. Continuing on the Council are MDs, Terrence N Hart,* Brookfield; Thomas P Lathrop,* La Crosse; William J Listwan,* West Bend; and Robert E Phillips,* Marshfield.

Edwin L Overholt, MD,* La Crosse, was designated an ex officio member of the Council as the American College of Physician's Governor of Wisconsin.

Robert F Madden, MD,* Milwaukee, was named as the recipient of the Society's 1985 Addis Costello Internist of the Year Award and William L Treacy, MD,* Milwaukee, was presented the 1985 WSIM Distinguished Internist Award. James A Means, MD,* Milwaukee, received a WSIM award of merit for his many years of service to the society as the membership chairman. Doctor Means is retiring from his post this year.

During 1984-85, over 80 new members were accepted into the organization.

Council of the American College of Surgeons, Wisconsin Chapter, held an interim meeting April 26 in La Crosse. Dr J David Lewis,* West Bend, presented a listing of ambulatory surgery procedures which he had developed based on a survey of Wisconsin surgeons and hospitals. This listing of procedures normally performed on an outpatient basis was to be circulated among the specialty groups for input and then distributed to the members.

Concerns with credentially and quality care at Wisconsin surgical centers were expressed. It was decided to meet with the Wisconsin Hospital Association to discuss the lack of regulations and control of surgical centers.

The Council affirmed a recommendation of Dr Sanford Mackman*, Madison, that the Wisconsin Chapter publicize the hazard of postsplenectomy sepsis and the availability of pneumococcal vaccine.

The Council's annual meeting will be held December 7 at the Marc Plaza Hotel in Milwaukee.
—*Roger L von Heimburg, MD,**
Green Bay

American College of Physicians has announced that Andrea Dlesk, MD,* Marshfield, was elected to fellowship in the ACP. Doctor Dlesk will be honored at the College's Annual Session to be held in San Francisco in April 1986. A 1976 graduate of Harvard Medical School, Doctor Dlesk is a member of the Marshfield Clinic and an assistant clinical professor at the University of Wisconsin in Madison.

Milwaukee Ophthalmological Society officers for the year 1985-86 have been announced as follows: Robert A Hyndiuk, MD,* Milwaukee, president; Robert W Pointer, MD,* Sheboygan, vice president; Jack L Hughes, MD,* Milwaukee, secretary; and Gregory P Kwasny, MD,* Milwaukee, treasurer.■

ADAMS-MARQUETTE-COLUMBIA: At the September meeting of the Adams-Marquette-Columbia County Medical Society, the following physicians were elected as officers for 1986: MDs Richard E Christianson,* Portage, president; Renato R Baylon,* Oxford, president-elect; Paul J Slavik,* Portage, secretary-treasurer; Robert T Cooney,* Portage, delegate; and Martin L Janssen,* Friendship, alternate delegate.

BROWN: Seventy-five members and guests were present at the September meeting of the Brown County Medical Society. Guest speakers included MDs Peri L Aldrich,* Don J Gallagher,* and John Stevens who spoke on the "Overview of Current Proposals on Alternative Delivery Systems." Mrs Deborah Bowen-Wilke, field consultant from the Physicians Alliance Division of the State Medical Society and Ms Sally Wencel, staff attorney for the State Medical Society, also were present to answer questions. New members accepted in the Society are MDs Marc H Anderson,* Green Bay; John F Andrews,* Green Bay; James Berner,* DePere; Steven A Halsey,* Green Bay; Paul C Hodges Jr,* Green Bay; James D McGovern,* Green Bay; Michael F Phillips,* DePere; Susan M Piechowski,* Green Bay; Roger H Strube,* Green Bay; Kevin P Wienkers,* Green Bay; and Robert C Zimmerman,* Green Bay.

RUSK: Forty-five members and guests were present at the September meeting of the Rusk County Medical Society to hear guest speaker Morris Davidman, MD, chief of the Department of Nephrology and director of the Kidney Disease Center at Hennepin County Hospital, Minneapolis, Minnesota speak on "Practical Aspects of Hypertensive Therapy."

WINNEBAGO: At the September meeting of the Winnebago County Medical Society, thirty-three members and two guests were present to hear J D Kabler, MD,* Madison, speak on "Headaches."■

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PHYSICIANS EXCHANGE

Internal Medicine: BC/BE. Established 50-doctor multispecialty group practice located in the Milwaukee, Wisconsin metropolitan area. Expanding practice needs two internists. Competitive salary and excellent fringe benefits. Address inquiries and CV to Medical Director, PO Box 427, Menomonee Falls, WI 53051. p10-11/85

Growing multispecialty clinic is looking for two family practitioners. One to staff a three-person Walk-In Department and the other to function in a traditional family practice setting located in North Central Wisconsin. New facility situated across the street from new hospital. Full partnership in two years. Easy access to lakes, woods, and mountains. Write including CV to D K Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p11-12/85;1/86

Family Practitioner. River Valley Medical Center is seeking two family practice Board eligible/certified physicians for its multispecialty group of 16 physicians in Northwest Wisconsin. Excellent starting salary and comprehensive fringe benefit package the first year with full group membership after one year. Attached to a progressive 90-bed hospital. We are within 45 minutes of the St Paul-Minneapolis area. Please contact Dr Carl Hansen, Recruitment Chairman or Tom Halverson, Clinic Manager, 208 Adams St, South, St Croix Falls, WI 54024; ph 715/483-3221. p11/85;12tfn/85

Women's OB/GYN Care, SC of Waukesha, Wisconsin, is seeking a BE/BC OB/GYN, including residents finishing '86-87, in a private, fee-for-services practice. This would add a *fifth* OB/GYN to our call schedule. Salary is negotiable with first year guarantee and early partnership. This 50,000 member community has solid support for patient centered OB/GYN care. Referrals from area general practitioners allow the OB/GYN to spend the majority of time practicing the specialty. Our nurse practitioner provides excellent patient education and preventive self-care. Our hospital is a Level #2 Obstetric facility with excellent pediatric colleagues, three of whom have neonatal experience. Wisconsin provides a myriad of outdoor and recreational activities and Milwaukee cultural events are only ½ hour away. Send CV to Dr Anne Riendl, PO Box 1907, Waukesha, WI 53187-1907; ph 414/544-2801. 11-12/85

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Resident in Thoracic & Cardiovascular Surgery wanted to perform surgery to correct deformities, repair injuries, prevent diseases, and improve function of the heart and thoracic cavity under supervision of hospital staff. Requires MD in medicine and one year experience as a resident in thoracic and cardiovascular surgery. $20,000 per year, 40 hours per week. Send resumes to Ben Loomis, 819 N 6th St, Milwaukee, WI 53202; ph 414/224-4208. J O #0254665 "Employer Paid Ad." 11/85

Directorship position available in a new ambulatory care center to open December 1985 in Milwaukee, Wisconsin. Board eligible/certified in family practice, internal medicine, or emergency medicine desired. Attractive compensation and benefit package. Contact: Ms Debbie Carsky, Director of Recruitment, (MESA) Medical Emergency Service Associates, SC, 15 S McHenry Rd, Buffalo Grove, IL 60089; ph 312/459-7304. 11/85

Family Practitioner wanted to share existing practice and fully-equipped medical office in Waushara County. Salary plus incentives and opportunity for eventual purchase of practice. Excellent recreational area, a great place to live and raise a family. Send inquiries to Roy Grunwaldt, Administrator, Wild Rose Hospital, PO Box 243, Wild Rose, WI 54984; ph 414/622-3257, ext 212. 11/85

Emergency Department Physician. South Central Wisconsin. Emergency medicine physician sought for progressive emergency department. Physician enjoys: independent contractor status, paid malpractice, flexible scheduling, and other significant benefits. Call Kim Dials toll-free at 1-800/231-0342. p11/85

Wisconsin, South Central. Board eligible/certified family physician sought for satellite facility in rural community of 2,400 as third member of a group. Opportunity to practice full spectrum family medicine. Facility within 15-minute drive of 68-bed, full-service hospital. Competitive first-year minimum guarantee, full benefits. Write or call: Joe Scholl, Fox Hill Associates, 250 Regency Ct, Waukesha, WI 53186; 414/785-6500. 11/85

Fifty-eight-year-old general practitioner seeking part or full-time work in outpatient medical practice. Considerable experience in student health work. Have Wisconsin license. Available reasonably soon. Interested in small communities. Contact Dept 571 in care of the Journal. p11-12/85

Wisconsin—Family Practice, Internal Medicine, and Urology physicians to work in Northern Wisconsin multispecialty clinics. Guaranteed first year salary plus fringes. Future partnership available. Send CV to R J Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 11/85

Wisconsin, Southeast. Family physician seeking Board eligible/certified partner. Practice located in rural community of 5,700 less than a 15-minute drive from 127-bed acute care hospital facility. Various recreational opportunities. Guarantee plus production incentive, full benefits. Write or call: Joe Scholl, Fox Hill Associates, 250 Regency Ct, Waukesha, WI 53186; ph 414/785-6500. 11/85

Surgeon wanted to solo in northeast Iowa near Mississippi River. Scenic and recreational area including hunting, fishing, boating. Two small community hospitals, 11 referring physicians, previously supporting one surgeon. Strong community and physician commitment. Hospital-based office practice. Interest in basic surgical orthopedics desired, but not required. Contact Dept 570 in care of the Journal. 11/85

Emergency physicians full or part-time. Positions available in a moderate volume emergency room in Beloit, Wis. Must have an active interest in community relations. ACLS required. ATLS desirable. If interested, contact John Maher, MD, Director, Emergency Department, Beloit Memorial Hospital, 1969 W Hart Rd, Beloit, WI 53511. 11-12/85

General Internist. Marshfield Clinic, one of the nation's largest multispecialty private groups, is seeking several Board certified/Board eligible General Internal Medicine specialists to join its expanding 16-member section. Internal Medicine Residency Program, University affiliation, Research Foundation, and large regional referral base contributes to a very stimulating environment. Unique big city medicine opportunity in a family-oriented rural setting. Please send curriculum vitae to: John P Folz, Assistant Director, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or call collect at 715/387-5181. 9-11/85

PHYSICIANS EXCHANGE

continued

Internist with or without subspecialty interest. Board Certified or eligible, to join six other internists in a well-established, 23-man expanding multispecialty group in prosperous lakeside southeastern Wisconsin city of 36,000. The Internal Medicine Department currently has subspecialties in cardiology, pulmonary medicine, and medical oncology. Liberal fringe benefits. Initial salary plus percentage as associate. Full status in service corporation, with incentive-oriented formula after first year. Contact J F Kuglitsch, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935; ph 414/923-7420 collect. 5tfn/85

Ophthalmologist, subspecialty pediatrics or glaucoma helpful but not required, Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Must be willing to do general ophthalmology. Immediate drawing area 100,000 with unopposed subspecialty referral area much higher. Located on Lake Michigan with excellent recreational activities. Optometric support available. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Radiologist-Board certified, available for part-time position for clinics in Milwaukee and neighboring counties. Contact Dept 567 in care of the Journal. 10-11/85

FAMILY PRACTITIONERS INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone 608/263-4095 7/85-6/86

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Family practice opportunity—very busy five-physician practice being covered by four physicians. Pleasant South Central Wisconsin community of 15,000; close to Milwaukee and Madison. Excellent recreational area. First-year guaranteed salary. Excellent benefits. Contact: C Burchardt, Medical Associates, 1200 N Center, Beaver Dam, WI 53916; ph 414/887-7101. 10tfn/85

General Internist. Board certified/board eligible. Opening established practice with large multispecialty clinic, Madison. Competitive salary, excellent fringe benefits. Send curriculum vitae and references to Dept 568 in care of the Journal. p10-11/85

Family Practice: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary gaurantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Emergency Physician. Seeking third full-time associate for modern, well-equipped emergency outpatient department. Lower volume ER. Thirty-five miles north of Green Bay. Board eligible, ATLS, ACLS certification desirable. Beautiful rural Wisconsin. Send inquiries with CV to Administrator, Community Memorial Hospital, 855 S Main St, Oconto Falls, WI 54154 or call 414/846-3444. 10-11/85

Orthopedic Surgeon sought by state-of-the-art multispecialty group in Milwaukee, Wisconsin. Board certified/eligible physician to join 3 other orthopedists in the performance of independent orthpedic evaluations for the purpose of determining appropriate treatment or disability. No weekends, no call, no surgery. Competitive salary and fringe benefits. Please submit CV to Dept 566 in care of the Journal. p10-11/85

Ophthalmologist. Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Immediate drawing area 100,000. Located on Lake Michigan with excellent recreational activities. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Pediatrics/Neonatology: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits, and early ownership. Neonatology skills needed for Level II Nursery. Please send curriculum vitae to R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Wisconsin: Pediatrician with subspecialty interest to join multispecialty clinic that includes general pediatricians, pediatric hematologist, oncologist and neonatologist in city of 150,000. Send CV to Dept 561 in care of the Journal. 8tfn/85

Internist-Infectious Disease Physician. The Racine Medical Clinic, a progressive cluster corporation of 32 physicians, is currently seeking an Internist-Infectious Disease physician. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 6tfn/85

Pediatrician. BC/BE to join busy four-member Pediatric Department within a 23-member multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 54303; ph 414/494-5611. 10-12/85;1/86

PHYSICIANS EXCHANGE

continued

Excellent opportunity for a Board certified or eligible internist to practice in conjunction with an 8-member Internal Medicine Department of a 26-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 6tfn/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

OB/GYN: BC/BE to join three OB-GYNs in 31-physician multispecialty group. Beautiful lakefront community of 90,000 located between Milwaukee and Chicago offers a wealth of cultural, educational, and recreational opportunities. Well-equipped clinic and two local hospitals; salary guarantee with incentive bonus; excellent fringe benefits and early partnership. Send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Primary care physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to: Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. 9-12/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

Family Practice. Third family practice physician needed to join multispecialty group of 17 in Hartford, WI. Two branch locations. All facilities modern and well equipped. Guaranteed first year negotiable salary; usual fringe benefits. Contact: Murlin Bernd, Clinic Manager, 1004 E Sumner St, Hartford, WI 53027; ph 414/673-5745. 10-11/85

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

West Bend, Wisconsin, General Clinic, a (18) physician multispecialty group, is seeking physicians in the specialties of Internal Medicine, Family Practice, OB/GYN, and Pediatrics. First-year salary guaranteed. Corporate membership possible after one year. Excellent fringe benefits. Located in scenic, recreational area with close proximity to Milwaukee. Please contact Hans W Schmelzling, Administrator, General Clinic, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 6tfn/85

ORTHOPEDIC SURGEON

Mid-Michigan community seeks orthopedic surgeon for service area of 90,000. Guaranteed first year income $150,000. Office space available in medical office building adjacent to the hospital. 214-bed hospital provides excellent diagnostic capabilities and new surgical facilities. Excellent opportunity for a physician seeking busy private practice opportunity with guaranteed success. Contact Vice President of Professional Service—517/723-5211, ext 1823.

p11-12/85;1-2/86

PHYSICIANS EXCHANGE

continued

Versatile Surgeon wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E Johnson, Ely Medical Center, Ltd, 224 East Chapman Street, Ely, Mn 55731; ph 218/365-3151. 6tfn/85

Board Eligible Orthopedic Surgeon to join established orthopedic practice in East Central Wisconsin. Contact Dept 553 in care of the Journal. 2tfn/85

Family Practice physician, BE/BC, to share fully equipped medical office in southeast Wisconsin with busy Board certified family practitioner. Opportunity for partnership. Near Milwaukee and Chicago, rural atmosphere. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to F M Zarbock, MD, Box 158, S89 W22915 Maple Ave, Big Bend, WI 53103. 11-12/85;1/86

MEDICAL FACILITIES

Office for rent January 1986. Now used for orthopedic surgeon. 32′ × 50′, including waiting room, business office, two large exam rooms, cast room, and office. Free parking. Baraboo, Wisconsin. Phone 608/356-6644. 11/85

Family Practice for Sale. Southeastern Wisconsin. Fully-equipped medical building with additional land for expansion. Physician wishes to retire in near future. Will assist in financing. Contact Mark Gorman, 4109-67th St, Kenosha, Wisconsin 53142; ph 414/654-9166. 11/85

General and surgical solo practice for sale. Gross in excess of $300,000. Growing desirable midwestern university city with population 25,000. One very well-equipped hospital in county of 60,000 a few blocks away. Owner will remain to introduce. Contact Dept 563 in care of the Journal. 9tfn/85

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MISCELLANEOUS

Physicians. Ultrasonography Service in your office. Milwaukee Ultrasonography Service offers to bring realtime ultrasonography to your personal office. Service now available in southeastern Wisconsin. For information, please call Nancy Schiller at 414/933-8795. 10-11/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

DECEMBER 7, 1985: Wisconsin Chapter American College of Surgeons, Marc Plaza Hotel, Milwaukee. g11/85

JANUARY 19–22, 1986: *New Therapeutics VI: The Results of Recent Advances in Medicine.* Telemark Lodge, Cable, Wis. Sponsored by University of Wisconsin School of Medicine and Continuing Medical Education. AMA Category I credit 14 hours, Family Practice credit pending, University of Wisconsin CEUs 1.4. Contact: Ann Bailey, Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53705; ph 608/263-2854. 11-12/85

Wisconsin Specialty Society Meetings 1985-1986

- Wisconsin Society of Pathologists, Nov 16, 1985, American Club, Kohler
- Wisconsin Chapter American College of Surgeons, Dec 7, 1985, Marc Plaza Hotel, Milwaukee
- Wisconsin Urological Society, Apr 11-12, 1986, Edgewater Hotel, Madison
- Wisconsin Academy of Family Physicians, June 11-14, 1986, Telemark Lodge, Cable
- Wisconsin Society of Obstetrics & Gynecology, July 17-19, 1986, Embassy Suites, Green Bay
- Wisconsin Dermatological Society, Aug 1-3, 1986, The Abbey, Lake Geneva

APRIL 11–12, 1986: Wisconsin Urological Society, Edgewater Hotel, Madison. g11-12/85;1-3/86

JUNE 11–14, 1986: Wisconsin Academy of Family Physicians, Telemark Lodge, Cable. g11-12/85;1-5/86

JULY 17–19, 1986: Wisconsin Society of Obstetrics & Gynecology, Embassy Suites, Green Bay. g11-12/85;1-6/86

AUGUST 1–3, 1986: Wisconsin Dermatological Society, The Abbey, Lake Geneva. g11-12/85;1-7/86

OTHERS

DECEMBER 4-6, 1985: (Illinois): *Neurology for the Non-Neurologist,* The Westin Hotel, Chicago. Contact: University Office of Continuing Education Rush University, 600 S Paulina, Chicago, IL 60612; ph 312/942-7095. p9-11/85

DECEMBER 5-7, 1985 (Minnesota): *Coronary Heart Disease: A Comprehensive Review of Principles and Practice,* Sheraton Midway Hotel, St Paul. Info: Bonnie Young, CME, St Paul-Ramsey Medical Center, 640 Jackson St, St Paul, MN 55101; ph 612/221-3977. g6-11/85

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

JANUARY–JULY 1986: (Minnesota): *Continuing medical education programs,* University of Minnesota Medical School, Minneapolis. See details in full-page ad elsewhere in this issue. g10/85

FEBRUARY 13-14, 1986 (Michigan): *Tenth Annual Winter Pediatric Conference* at Powderhorn Ski Area, Ironwood, Michigan. Guest speaker is James A Stockman, III, MD. Info: Marshfield Medical Education Department or H James Nickerson, MD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wisconsin 54449. 9-12/85; 1-86

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WEEKLY SEMINARS

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JUNE 15–19, 1986: Annual AMA House of Delegates, Chicago, IL.■

DECEMBER 7–10, 1986: Interim AMA House of Delegates, Las Vegas, NV.

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

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State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1986–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel.

1986—April 17–19
1987—March 26–28
1988—April 28–30
1989—April 13–15
1990—April 26–28
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Too Tall, Too Small. By John S Gillis, PhD. Institute for Personality and Ability Testing, Inc, PO Box 188, Champaign, IL 61820. 1982. Pages: 187. Price: $12.95.

Correlative Neuroanatomy & Functional Neurology. 19th edition. Edited by Joseph G Chusid, MD. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1985. Pages: 513. Price: $19.50.■

ADVERTISERS

Acme Laboratories 50
Advanced Technology Associates, Inc 41
Medical Computer Systems
American Physicians Life 4
Ayerst Laboratories 38, 39, 40
Inderal® LA
Dista Products Co (Div of Eli Lilly & Co) 8
Keflex®
Dorsey Pharmaceuticals (Div of Sandoz, Inc) 27, 28
Hydergine® LC
Gaarder Miller Milwaukee Ltd 33
House of Bidwell 25
Marion Laboratories 19, 20
Cardizem®
Med Flight 48
Medical College of Wisconsin 35
Physician Resource Network
Medical Protective Company 36
Navy Medicine 7
PBBS Equipment 7
Peppino's 34
Professionals Insurance Company, The 29
Roche Laboratories . . . . . 57, BC
Dalmane®
S&L Signal Company 50
SMS Services, Inc 47
Upjohn Company, The 37
Motrin®
Wisconsin Clinic Credit Managers Association . . . . . 34■

NEWS YOU CAN USE

EFFECTS OF AN EXTENDED FEE FREEZE. According to a recent article published in the September issue of *Medical Economics,* members of the American Society of Internal Medicine indicated that a continued Medicare fee freeze would harm more patients than it would help. Nearly nine out of ten internists currently participating in Medicare say a continued freeze would force them to drop out which, in turn, would limit access for the elderly and increase their out-of-pocket expenses. According to the internists surveyed, 31% indicated another freeze will cause them to lay off employees or reduce their salaries/hours; 30% said they would accept assignment less often; 28% said they would curtail services; 16% would shift costs to non-Medicare patients; 15% would refuse new Medicare patients, and 8% would take early retirement.■

CME CREDIT DEADLINE APPROACHING. Continuing Medical Education credits for all physicians must be completed by December 31, 1985 to assure license renewal for the coming biennium. Thirty (30) hours of Category 1 credits approved through the AMA's Physician Recognition Award (PRA) program are required. The process of requiring physicians to attest to their having completed the coursework begins in late November and early December. More than 50 hospitals and 30 specialty societies are accredited by the State Medical Society of Wisconsin as sources of obtaining the CME credits. These accrediting bodies are listed in the June BLUE BOOK issue of *WMJ.*■

INSURANCE RATES HIGHER FOR SOME MICHIGAN PHYSICIANS. Michigan's second largest physician malpractice insurance company has increased its rates for some of its insured physicians participating in preferred provider organizations (PPOs) and independent practice associations (IPAs). The increase followed a study by the company, Physicians Insurance Co of Michigan, that showed that physicians participating in PPOs or IPA/HMOs were 20 to 35 percent more likely to lose their malpractice suits than physicians who do not participate in these types of arrangements. Premium surcharges ranged from 25 to 100 percent of the 1985 premium, based primarily on whether the physicians had claims histories, licensing problems, or incidence of drug or alcohol abuse.■

QUACK CURES are exposed as fraudulent in information packets from the AMA Division of Library and Information Management. Physicians, the federation, and the public may obtain information packets on unscientific nostrums ranging from colonic irrigation to hair analysis. The library's existing literature covers nearly 80 subject areas, including alternative cancer and arthritis cures, allergy testing, and baldness remedies. When the library does not have material to answer a query on a quack cure, the staff provides a computerized literature search to help the caller. For more information, contact Micaela Sullivan, research associate, Division of Library and Information Management, AMA headquarters, Chicago. The telephone number is (312) 645-4846.■

VOLUNTEER RELIEF ACTIVITIES IN MEXICO CITY. The *American Medical News* is interested in contacting physicians who have first-hand information about conditions in Mexico City or who are or have been involved in volunteer relief activities in the aftermath of the earthquake in September. Physicians are asked to contact Barbara Bolsen at AMA Headquarters: 312/645-4428.■

PHYSICIAN SERVICE OPPORTUNITIES OVERSEAS. The Dec 14, 1984 issue of *JAMA* contained a directory, entitled *Physician Service Opportunities Overseas,* which listed more than 170 organizations that recruit US physicians for both long- and short-term assignments in a host of countries around the world. Included is a list of factors that physicians must think about in considering overseas service. For further information physicians may contact Kimberly Glasbrenner of the *JAMA MEDICAL NEWS* staff: 312/645-7145.■

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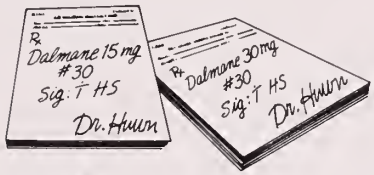

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Medicine: Trade or profession?

President Scott in his President's Page points out that the term "profession" can be interpreted as benign or highly charged depending on one's point of view. He cites a 70-year-old definition of a profession as an occupation with certain criteria and believes it is "valid today and if adhered to would not lead to the present corruption of the term 'profession.' " (See page 5)

Medical liability not alone in "crisis"

An editorial entitled "Telling testimony" points out the fact that there is a *serious crisis* in medical liability in Wisconsin but the problem is not limited to medical care. "The crisis in medical liability coverage is reflected over and over in a whole host of areas where the threat of a lawsuit and attendant liability threatens continuation and availability of a variety of necessary activities and endeavors." (See page 6)

'Required request' for organ transplantation?

Professor Peters of Stevens Point offers a practical proposal for increasing the supply of cadaver organs for transplantation and urges Wisconsin's Legislature to enact a 'required request' law similar to those in the states of New York and Oregon. (See page 10)

SMS membership reaches new high

Record numbers of physicians have joined SMS and their county medical societies in 1985. By mid-November total SMS membership had reached 6,472, an increase of 12.5% over 1984 levels. (See page 31)

DECEMBER
1985

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CONTENTS

December 1985

SPECIAL FEATURES

President's Page

5 Medicine: Trade or profession, by *John K Scott, MD,* Madison

Editorials

6 Telling testimony

6 Long-wear contact lenses, by *Victor S Falk, MD,* Edgerton

7 My white hat, by *Victor S Falk, MD,* Edgerton

Letters

7 New drugless healers?, by *William J LaJoie, MD,* Wisconsin Society of Physical Medicine and Rehabilitation

8 Let's control our own destiny, by *William J Maurer, MD,* Marshfield

8 Milwaukee brace, by *Frederick G Gaenslen, MD,* Milwaukee

Special

10 Required request: A practical proposal for increasing the supply of cadaver organs for transplantation, by *David A Peters, PhD,* Stevens Point

13 Contact lenses: Boon or bain?, by *Frederick J Davis, MD,* Madison

57 INDEX: *Wisconsin Medical Journal,* Vol 84, January 1985 through December 1985

Miscellaneous

15 AMA Physician's Recognition Award recipients

50 Blue Book update

Socioeconomics

43 State Medical Society Legislative Status Report

46 AIDS bill becomes law

News you can use

72 Health prospects 1983/2003 survey reported

72 Council on ethical and judicial affairs

72 JCAH announces new quality review bulletin

72 AMA says Supreme Court action on California malpractice law is 'significant'

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 84 No. 12

CONTENTS

STATE MEDICAL SOCIETY OF WISCONSIN

SCIENTIFIC MEDICINE

19 Review of the clinical manifestations, laboratory findings, and complications of infectious mononucleosis, by *Lynn Rosen White, MD* and *Peter S Karofsky, MD,* Madison

25 CLINICAL CANCER: New discoveries in oncology: Potential applications to clinical practice, by *Henry C Pitot, PhD,* Madison (Number 1 of a series)

ORGANIZATIONAL

30 Membership facts

31 SMS membership reaches new high

31 H/D Nominating Committee selects slate of candidates

31 President-elect Landis will not serve office

32 1985 Leadership Conference participants

33 Governor Earl addresses SMS Leadership Conference

33 Dr Treffert named to statewide professional discipline task force

34 Max Goodwin Physician—Citizen of the Year

37 Membership Directory—Update

49 OBITUARIES:
George Colville Owen, MD Milwaukee
Benjamin E Urdan, MD Milwaukee
Moktar Najafzadeh, MD Miami, Florida (Twin Lakes)
Gerald J Bergmann, MD Greenfield
James D Zeratsky, MD Marinette
Anthony S Kult, MD Milwaukee

66 CES FOUNDATION: Contributions during the month of October 1985

DEPARTMENTS

48 COUNTY SOCIETIES: Lincoln (CMS offers free colorectal screening) . . . Marinette-Florence . . . Outagamie . . . Sheboygan . . . Winnebago

50 NEWS HIGHLIGHTS: Columbus Community Hospital . . . Marshfield Clinic . . . St Mary's Medical Center

51 PHYSICIAN BRIEFS

67 MEDICAL YELLOW PAGES: Physicians exchange . . . Medical facilities . . . Miscellaneous . . . Medical meetings/continuing medical education . . . Advertisers ■

THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 6200 member physicians in Wisconsin, comprising 55 county medical societies and 26 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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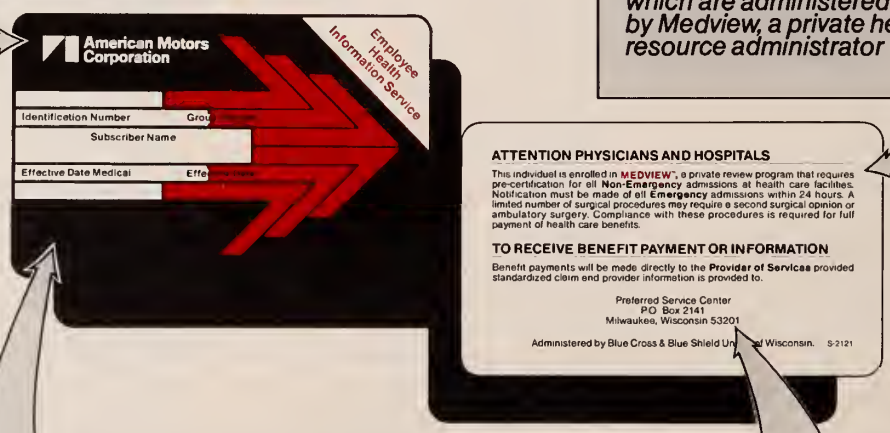

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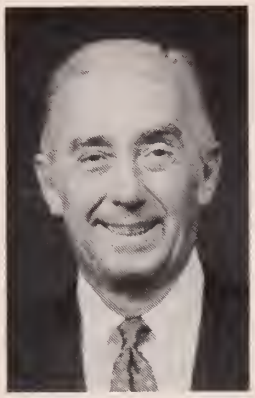
Medicine: Trade or profession?



John K Scott, MD

THE TERM "profession" can be interpreted as benign or highly charged depending on one's point of view. The Latin root, profiteri, conveys a sense of promise, confession, or commitment. Over time the term has come to mean a public claim of special knowledge or skill in some particular area.

Justice Brandeis once defined a profession as an occupation (1) for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent learning as distinguished from mere skill; (2) is pursued largely for others and not merely for one's self; and (3) in which the amount of financial return is not the accepted measure of success.

Even though Brandeis stated his definition more than 70 years ago, it is valid today and if adhered to would not lead to the present corruption of the term "profession."

The so-called "learned professions"—originally medicine, law, and divinity—demanded profound academic study. The knowledge thereby acquired set the members apart from the laity who, lacking such knowledge, depended on the statements and acts of the professional. Members of a profession thus found themselves in a position of authority and service based on trust. This dual relationship imposed on members of the professions a particular moral obligation often made more explicit by a code of ethics. Certainly this has been true of the medical profession.

The unselfish devotion attributed to physicians is, however, subject to disintegration as is the whole concept of a profession as each is affected by the changing social and economic structure. Service, once the keystone of a profession, is now everybody's activity. With that change has come the view that the rendering of specialized service alone constitutes professionalism.

Who today denies the name "professional" to the auto mechanic, the hairdresser, the watchmaker, the investment counselor, the travel agent, or the airline hostess? At one time the activities they represent would have been called "trades," meaning skilled work not requiring a high level of education and certainly distinct from a profession. The intense competitiveness of the occupations combined with liberal advertising further clouds the older sense of a "profession." Hence the query: Is medicine a trade or a profession?

Some suggest there is little difference between business, the trades, and the professions. To most of us, however, such a statement induces a nagging uneasiness. There is a tradition in medicine. There is an undying sense of the older professionalism. Even though physicians are incorporated, business managers take over our offices, and the term "industry" is applied to medical and health care, the tradition of the professional, almost ghostlike, will not disappear.

Happily, most of us continue to believe that the needs of the patient should come first, that medical service is not a commodity of the marketplace, that our profession involves scholarship and intellect above and beyond mere skill, and that service rendered with an eye on the cash register is not really service but business.

F Scott Fitzgerald's observation on the importance of being able "to hold two opposed ideas in the mind at the same time and still retain the ability to function" is relevant here. Physicians and indeed their regulators must act in full awareness of medicine's dual nature: financial considerations can never be fully put aside, but we function primarily as the servants of our patients' needs.

Medicine is certainly both a profession and a business and it no longer stands out from innumerable other "professions." Let us hope, however, that some of the old values will persist, unchanged. It will be a sad day for America if physicians ever come to be seen as tradespeople. It will also be a sad day if physicians have a higher image of themselves than the public has of physicians. Pious words will then have no effect.■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

Telling testimony*

THERE IS A *serious crisis* in medical liability in Wisconsin. It is a crisis of insurance affordability for physicians *and* patients, and it is rapidly also becoming a crisis of *availability* of care for some patients in some areas of the state.

The problem is not limited to medical care. The application of the tort system to professional liability is generating a crisis in insurance availability and affordability for engineers, architects, nurse midwives, municipal units of government, and even attorneys themselves. The depth and breadth of this problem is serious—so serious that a special session of the Legislature had to be held to attempt to resolve the problem for the dispensers of alcoholic beverages. The solution was the elimination of that liability exposure.

The crisis in medical liability coverage is reflected over and over in a whole host of areas where the threat of a lawsuit and attendant liability threatens continuation and availability of a variety of necessary activities and endeavors. For example, why should companies continue to produce vaccines when lawsuits for product liability cost those companies 200 times the profits from those vaccines?

There is something dreadfully wrong with a system that ultimately sees less than 30 cents of each dollar awarded to the victim while the majority of that dollar goes to the legal system and insurance system supported by the vast medical liability industry.

We are not opposed to compensating victims for true medical negligence. We are opposed to a system that rewards the advocates in the industry more than it awards the victims.

Medical negligence does occur. In some instances this is by incompetent medical practitioners. Medicine continually strives to improve the practice patterns of physicians and to discipline physicians who fail to meet high ethical and clinical standards. The peer review and discipline provisions of Senate Bill 328—the "so-called medical liability bill"—and the 1985 biennial budget bill provisions are important steps toward improving that system.

However, eliminating the few physicians with multiple awards or settlements is not the only solution. A much broader and more complex problem is the public expectation that there should be protection not only against malpractice but also what might be called "maloccurrence."

In the minds of the public, and in the minds of juries, tragic and untoward maloccurrences become confused with malpractice. Malpractice awards have often come not to represent simply negligence, but rather a system of compensation for persons visited by some untoward outcome unavoidable and unanticipated.

If malpractice has come to mean something other than negligence, and if claims equate to compensation, as Attorney Melvin Belli has stated for example, then a major restructuring of the tort system is necessary to avoid chaos and bankruptcy of any medical liability plan.

The medical malpractice crisis is the tip of the "let's sue" mentality that threatens to sink all of society's activities—charitable, professional and business—in a paralyzing sea of inactivity under threat of suit or actual bankruptcy under cost of suit.

SB 328 is the first step on the road to reform and the Society commends Senator Jerome Van Sistine and the Legislative Council Special Committee for the development of this proposal.

*Excerpts from testimony before the Senate Committee on Labor, Business, Veterans Affairs & Insurance, Green Bay, Wisconsin, November 13, 1985 regarding medical liability and SB 328, by Darold A Treffert, MD, Fond du Lac, Chairman of the State Medical Society's Board of Directors.

Long-wear contact lenses

THE *CAPITAL TIMES*, a Madison newspaper, recently published a series of articles describing the hazards of extended-wear soft contact lenses. The subject was thoroughly researched and accurately reported.

On the basis of this series, the Optometry Examining Board has directed the State Department of Regulation and Licensing to draw up rules spelling out how the warnings are to be presented.

It seemed appropriate for the *Wisconsin Medical Journal* to inform Wisconsin physicians about some of the problems resulting from the poorly informed users of extended-wear soft contact lenses. Consequently, Dr Frederick J Davis was asked to provide us with such an article. Doctor Davis recently retired after 35 years as an ophthalmologist with the Davis-Duehr Eye Associates of Madison. He also is Emeritus Associate Clinical Professor of Ophthalmology at the University of Wisconsin Medical School. Doctor Davis was a pioneer in the field of contact lenses. He has no axe to grind since he is no longer in active practice.

The *Wisconsin Medical Journal* is appreciative of Doctor Davis's

prompt and knowledgable response. His article is published in this issue.

—*Victor S Falk, MD,* Edgerton

My white hat

LAST YEAR after considerable thought and discussion, I elected not to sign up for the acceptance of all Medicare claims. I would continue to accept many of these as I had always done, but not all. This year after reviewing the information sent out by Medicare, the AMA and our own state society, I decided to become one of the good guys with the white hats. I signed the agreement to accept all Medicare payments effective October 1.

Our office manager very carefully submitted separate statements to Medicare for services rendered through September 30 and for those on or after October 1. What happened? Within days irate patients began calling the office stating that all of their Medicare claims prior to October 1 had been denied.

I became diffused in a patriotic aura. My face was red, my white hat turned to white heat, and the air was blue as I gave vent to my frustration.

Several calls to the Medicare office revealed that mistakes had been made and attempts would be made to try to correct them. The computer, you know. Of course, what comes out of a computer depends entirely on what is fed into it.

Without becoming patently paranoid, it seems that we just can't win.

—*Victor S Falk, MD,* Edgerton ■

LETTERS

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

New drugless healers?

TO THE EDITOR: A new bill, Assembly Bill 256, soon will be considered for a vote by our state legislators. This bill is essentially a product of the Wisconsin Physical Therapy Association, Inc (WPTA). The purpose of this bill is to allow physical therapists to practice without any referral from a physician; it would allow physical therapists to evaluate and treat patients without any medical referral. In other words, they would be allowed to practice in the same way as chiropractors.

The WPTA takes the position that they are, by training, perfectly qualified to do this. They state, "Today's physical therapists are well qualified, both by education and clinical training, to ***evaluate a patient's physical condition,*** (editorial emphasis added), assess his/her physical therapy needs, and if appropriate, safely and effectively treat the patient." The WPTA claims, "Because of the skill and reputation of physical therapists, increasing numbers of patients are requesting physical therapy services and ***are frustrated to find they must first be seen by a referring practitioner.***" (editorial emphasis added) It is the intent of the WPTA to have physical therapists decide which of their patients should be seen by a physician! The WPTA states, "Furthermore, by eliminating the referral requirement (physician referral) the potential for ***referral for profit would be reduced.***" (editorial emphasis added) The WPTA further states, "Practice without referral would allow physical therapists to treat patients with established diagnoses, such as ***rheumatoid arthritis, multiple sclerosis, etc, without the patient having to incur the additional expense of seeing a referring physician.***" (editorial emphasis added) They state, "Practice without referral will allow physical therapists to become an entry point into the healthcare system."

It appears obvious from the statements made by the WPTA that if Assembly Bill 256 is passed, we will have a new group of "drugless healers." Unless there is a widespread opposition to this bill by *ALL* Wisconsin physicians, this bill will surely pass. The WPTA is well organized and they are making an all out effort to see that this or some equivalent bill is passed in the Legislature.

William J LaJoie, MD, President
Wisconsin Society of Physical Medicine and Rehabilitation

continued next page

Med student offers perspective on physical therapy

Editor's note: The following letter, written by a fourth-year medical student at the University of Nevada School of Medicine, also offers a perspective on physical therapy. It was published in the October 18, 1985 issue of *American Medical News.*

* * *

To AM News: Your article "Private practice of physical therapy on the increase" (*AMN*, Sept 13, 1985) demonstrated the difference of opinion between the physician and physical therapist concerning treatment without referral by the therapist. I believe I can offer an additional insight in that I am both a physical therapist and am presently completing medical school.

Prior to entering medical school I had a successful private practice physical therapy office. As the state legislative chairman, I sought to change the state law allowing a therapist to treat without physician referral. I felt I could better initially evaluate a patient than a physician and wanted to generate my own patient load, thus having better control of my practice.

During medical school I quickly realized there is a vast amount of pathology associated with musculoskeletal pain or dysfunction, which physical therapists have not been exposed to. The master's physical therapy program I attended was excellent and the information covered was in-depth, but the knowledge to enable a therapist to adequately screen patients was grossly lacking. For a therapy curriculum to adequately train a therapist to initially evaluate and diagnose, two additional years would need to be added: one year of pathology and pharmacology, and one year of hospital clerkships rotating through the basic areas.

There are two major problems with therapists treating without referral. The first is that they have not been trained to recognize many disease processes that will result in harm to the patient or at best waste their time and money. Most low back pain, for instance, is of a muscular-skeletal etiology for which physical therapists will treat effectively. But those few patients whose problem is of a different etiology, which will be missed by therapists, makes the whole concept of treatment without referral a disservice to society.

The other problem is therapists are unable to prescribe medications. The vast majority of therapy patients seen as outpatients greatly benefit from muscle relaxants, analgesics, or occasionally antibiotics. In fact, as seen in the past, most therapy candidate patients do well with these medications and rest alone. In those states that allow therapists to treat without referral, the patient would not have the benefit of medications immediately and at best would have to wait until he could be seen by a physician.

The legislative momentum for physical therapists to treat without referral is increasing. Physical therapy training is inadequate to enable them to properly act as medical screeners. If they wish to do so, therapy curriculums must be drastically enhanced or better yet, apply to medical school.

—*William S Muir*
Las Vegas, Nevada

Milwaukee brace

TO THE EDITOR: I wish to call your attention to an error which I think needs to be corrected. In your comments "that made Milwaukee famous" (August issue) you attribute the invention and design of the Milwaukee brace to Dr Walter Blount.

The truth of the matter is that Dr Albert C Schmidt invented and designed the brace and with the collaboration of Doctor Blount perfected it and popularized its use.

I hope this information is used to correct the situation.

—*Frederick G Gaenslen MD*
1031 North Astor St
Milwaukee WI 53202

Let's control our own destiny

TO THE EDITOR: The State Medical Society of Wisconsin is composed of and supported by physicians in a wide variety of medical practices including private solo small and large group, prepaid or HMO-type, government service, and academic medicine.

Giving front page coverage to unsubstantiated opinions such as "There is great danger in this (HMO movement)" and that "Physicians have some responsibility to try to reverse this process" is really reactionary and counterproductive.

Perhaps there is a great danger in the movement when looking at it from the long-term perspective of physicians' reimbursement and/or salaries, but to attack the prepaid medical care system on the basis that to quote Doctor Rengel "The patient's best hope for a committed relationship with his personal physician has been severely compromised by this trend" is overstating the case.

I believe it is readily apparent that those familiar with prepaid medical care as a financing mechanism realize that we stress the traditional committed relationship between the personal physician and his patient and that we are able to practice the highest quality medical care with all its interpersonal relationships within the framework of an HMO.

continued next page

Perhaps those physicians who are the most knowledgable and dedicated advocates of the patients and who wish to retain the quality of care should take charge of the HMO movement and the medical care financing and delivery system. In doing so, they will be taking charge of their own destiny and control the changes that occur rather than reacting to the changes.

William J Maurer, MD, President
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Required request: A practical proposal for increasing the supply of cadaver organs for transplantation

David A Peters, PhD, Stevens Point, Wisconsin

APPROXIMATELY 14,000 people each year could benefit from heart transplants.[1] Another 4,000-5,000 could be helped by liver transplants.[2] Close to 13,000 people now await kidney transplants.[3] The demand for organs vastly exceeds the supply.

State Uniform Anatomical Gift Acts (UAGAs), which govern the removal and transfer of organs from cadavers for medical use, declare that organs may be removed from a deceased person only if that person has given explicit prior consent or his/her family permits such taking immediately upon the death of their relative.[4]

Organ procurement agencies and other interested organizations, such as the National Kidney Foundation and the National Liver Foundation, have long been involved in public education programs designed to encourage people to sign donor cards. These groups also have contacted critical care staff in hospitals and urged them to be on the alert for potential donors dying in their institutions. Despite these recruitment efforts, few organs are retrieved from cadavers. Of the 20,000 individuals dying each year under conditions conducive to organ retrieval, organs are obtained from less than 15%.[5]

The nation's organ procurement works poorly for several reasons. First, transplant surgeons uniformly refuse to remove organs from brain-dead individuals without family consent. They do so irrespective of whether the decedent has signed a donation document. One reason why physicians adhere to this practice is because they fear being sued by distraught families who resent not being consulted about organ removal from their loved ones or who explicitly object to this procedure. While state UAGAs authorize physicians to remove organs and tissues from brain-dead *declared* donors without family consent, physicians are simply not confident enough that the law permits them to do this purely on the strength of the decedent's signed donor card.

Surgeons require family permission also because they do not wish to gain the reputation of being organ "vultures" who are insensitive to the needs, emotions, and values of the bereaved kin. Many physicians believe as well that it is simply unethical not to ask the family, since the deceased is of their own flesh and blood.[6]

Current surgical practice, then, requires that the families of both declared and undeclared brain-dead potential donors be asked about organ donation from such patients before physicians take the organs. But hospital personnel (especially critical care staff) who might ask families about organ removal from deceased kin often do not do so because

1. they feel it is too ghoulish a request to make of a grief-stricken family, or
2. they are not certain what hospital policy is concerning organ retrieval, or
3. they are not committed zealously enough to the organ procurement effort.[7]

This is the second major factor contributing to the poor rate of organ retrieval. Of course, if no one makes the request, organs that might have been obtained by family consent are lost. When asked about donating organs from dead relatives, about 60%-80% of white families consent.[8] Families who agree to donate organs from relatives almost invariably say later that they appreciated being asked because it gave them a chance to bring some good out of a tragic loss.[9] It is reasonable to believe, then, that if we don't routinely ask families about organ removal from deceased kin, not only are we wasting many useful organs but also we are denying families an important therapeutic outlet.

Arthur Caplan of the Hastings Center has recently proposed a promising way of mitigating these problems. Caplan calls it the policy of "required request."[10] Under this arrangement no hospital could disconnect a brain-dead potential donor from a respirator and write a death certificate until evidence were produced that available next of kin had been asked about the possibility of organ donation from the deceased. The chief virtue of the policy is that it ensures that families of qualified donors are asked about organ donation. This would presumably improve the

Professor Peters is Adjunct Associate Professor of Philosophy, University of Wisconsin-Stevens Point, and Director, The Institute for Health Policy and Law at Stevens Point. Reprint requests to: David A Peters, PhD, % Health Sciences Library, St Michael's Hospital, 900 Illinois Ave, Stevens Point, Wis 54481 (ph 715/346-5092). Copyright 1985 by the State Medical Society of Wisconsin.

rate of organ retrieval and uniformly provide families the therapeutic benefits described above.

An additional advantage of the Caplan policy is that once the public realizes that a hospital will automatically ask about organ donation in such circumstances, families will be prepared for the request. The policy creates a salutary pressure upon families to discuss organ donation before actually losing one of their members.

The policy also could resolve a number of other practical problems with organ retrieval. In many cases a head-trauma victim's wallet or purse containing his/her donor card gets separated from the victim during rescue or hospital admission procedures. If the victim dies, the donor card is frequently not sought or readily producible. If it is found but not signed, it is hard to know whether the patient would have approved of organ removal. The victim's family is most likely to know the answer to this question. Again, routine family inquiry is indicated.

Lastly, under the provisions of Wisconsin's UAGA, the family has the legal right to donate organs from a deceased family member if

1. the latter has not signed a donor card, or
2. a donor card cannot be found, and
3. there is no evidence that the decedent, while alive, objected to postmortem organ removal.[4]

If the family of a brain-dead potential donor is not approached about the possibility of organ removal and transfer from their loved one, they are not being given an opportunity to exercise a right which they possess under law. The policy of required request, then, can be interpreted as mandating that the family of a potential donor be "read their rights," as it were, so that they may act upon them.

Suppose a hospital staff person judges that a family is so emotionally distraught as a result of the unexpected death of their loved one that they would be psychologically devastated by a donation request. Does the policy of required request demand that the inquiry be made irrespective of the likely deleterious consequences to survivors? No. Caplan suggests that in this situation the hospital representative be allowed to exercise discretion and be permitted to forego approaching the family if he/she honestly believes that the family would be harmed by such a request. But in such a case, Caplan insists, the hospital staff person should be required to put into writing the reasons why he/she did not make the otherwise mandated inquiry.[11] This restriction is designed to discourage critical care staff from shying away from approaching families of potential donors because they are psychologically uncomfortable about doing so.

Caplan also insists that the physician who pronounces death be prohibited from inquiring about the donation.[12] This restriction is aimed at preventing or reducing family suspicions that the person making the request has prematurely declared death in order to quickly salvage the patient's usable organs. If this is a defensible restriction, it raises the question of whether the same conflict of interest issue arises in connection with family inquiries made by anyone directly connected with the critical care of the decedent. If this is a legitimate and important problem, the option remains of requiring that the person who conducts the family interview be someone who has been not at all involved in the final treatment of the patient; *eg*, a member of the pastoral care team or some other medically disinterested party. Caplan recommends, and I agree, that some agency in the state (*eg*, the Department of Health) be charged with setting standards for the training of persons who will be responsible for requesting donation. Not every person opportunely placed to make the request has the background necessary to perform this task in an informed and humane manner.[9]

A third problem connected with implementing Caplan's policy has to do with protecting the autonomous choice of individuals who have officially registered a decision to make their organs available after death by signing a donation document of some type; *eg*, a driver's license donor card.

Wisconsin's UAGA, like most state UAGAs, does not give a family the right to veto the written declaration of a deceased relative to serve as a donor. The policy of required request might be wrongly interpreted as granting such authority to the family. The UAGA gives paramount authority to the *individual* to decide whether his/her organs will be available for medical use after death. Hospital staff must therefore use a different approach in speaking with families of declared donors than they use with families of potential donors who have not signed donation documents.

The family of a declared donor must be informed that the decedent's signed card confers on the institution or person functioning as donee; *ie*, as recipient of the gift, a legal right to take the decedent's organs *without family consent* for use in accordance with those purposes specified by the donor.[13] As a matter of courtesy, the family should of course be informed about what the hospital is preparing to do to carry out the wishes of their dead relative to serve as a donor. Following standard interview procedure, procurement staff will attempt to answer those

questions most frequently asked by lay persons about organ donation (*eg,* "Will it disfigure the body and prevent open casket viewing?" "What is meant by 'brain death'?" "Will organ removal jeopardize the possibility or quality of life in the hereafter?").

In the unlikely event that the family still opposes organ removal from the declared donor decedent, I suggest that the procurement staff person ask the family, as a matter of policy, to sign a brief written *declaration of dissent* form. This document will be a request to the donee—*ie,* the person or institution authorized to receive the anatomical gift (in most cases this will be the attending physician)[14] —to waive his/her right of access to the gift for reasons cited by the family on the dissent form. I call this the "minimum burden of proof requirement." While the donee's waiver will be automatic, requiring the dissenting family to put into writing the substance of their objection has a number of important advantages.

First, it gives a more appropriate degree of recognition to the paramount rights of declared donors and donees under the UAGA than is provided either by present policy (which usually never apprises families of registered donors of these rights) or a policy which gives these rights mere token recognition. An example of the latter would be a policy in which procurement personnel inform families of deceased designated donors of the interlinked rights of the decedents and donees, but then deal with these families as if these rights placed no constraints whatever on the families' behavior; that is, after families are apprised of these rights, procurement staff straightaway ask these families for permission to remove organs from relatives who have personally authorized this procedure before death.

The token recognition policy would communicate to the family the following message: "The decedent and donee have these rights, but we (procurement staff) don't take them seriously, and we don't expect you to either. So we ask your consent to this procedure before giving effect to the decedent's stated wishes." While this policy is not a *complete* sellout of the rights of registered donors and donees (the rights are at least announced in the family interview), these rights are not allowed to qualify family authority in any way.

The distinction between this policy and current procurement practice, which routinely ignores the different legal topographies of cases in which potential donors have signed donation documents and cases in which they have not, is vanishingly small. The token recognition policy is an *almost* complete sellout of the rights of declared donors and donees under the UAGA. The policy I recommend is less vulnerable to this change.

Secondly, I doubt whether the rights-acknowledging policy I am proposing will estrange the public from the organ procurement movement and in this way jeopardize the goal of maximizing the number of organs obtained for transfer to patients facing imminent death from end-stage organ diseases. The burden placed on an objecting family to complete a dissent form is not onerous, although it is a significant exercise which expressly acknowledges the rights of donor and donee which are paramount in the situation. The family gets their way without having to argue for their position in a face-to-face interchange with the donee and without having to go to court (the donee's waiver is automatic). The consciences of family members must stand as the final judge of the adequacy of their reasons for requesting that organs not be taken from the decedent as he/she desired.

Thirdly, the policy makes it clear to the family that *they* cannot abort the retrieval procedure; only the donee can do this by waiving his/her legal right of access to the gift.

Some might object that the minimum burden policy still permits selling out the rights of declared donors and donees in deference to the contrary wishes of decedents' families—which is strictly illegal under the provisions of the UAGA. However, is a policy of never yielding to the objections of such families (and being prepared to defend the rights of donors and donees in court if necessary) worth its likely costs: alienation of the public and so reducing the number of organ donations made by families in circumstances where they *are* authorized by the UAGA to decide whether organs will be removed from a deceased relative, in cases, namely, where potential donors have *not* signed donation documents and have not registered prior objection to the posthumous taking of their body parts?

I suggest that since the public currently has little personal commitment to donating organs,[15] the policy of minimum burden of proof achieves an acceptable balance between the two principal competing interests at stake when a deceased potential donor has authorized posthumous donation: (1) the rights of the donor and donee generated by this formal authorization, and (2) the long-term success of the organ retrieval effort.

In the past six months state legislatures in New York and Oregon have passed required request laws based on the Caplan model.[16,17] I urge that we enact similar legislation in Wisconsin. But whether we retrieve organs under a required request policy or not, hospital interviewers must bring the rights of declared donors and the corresponding rights of donees to

the attention of the surviving families of such donors. If they don't, they defeat the important protections given to the autonomous choice of declared donors under the Uniform Anatomical Gift Act.

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Contact lenses: Boon or bain?

Frederick J Davis, MD, Madison, Wisconsin

In the past several years the use of "extended wear" soft contact lenses for "up to 30 days" correction of myopia has been highly promoted and advertised by chain store and discount optical outlets. Ophthalmologists are seeing an alarming increase in vision-threatening complications, most notably Pseudomonas corneal ulcers, secondary to these lenses. The use of extended wear lenses, except for a pressing visual or occupational need, and their prescription by medically uneducated individuals, is to be strongly condemned.

PRIOR TO 1947, the only indication for contact lenses was in an attempt to give useful vision to the unfortunate individual who had corneal scarring, irregular astigmatism or keratoconus, and who could not achieve reasonable vision with glasses. These lenses were moulded polymethylmethracrylate (PMMA) or blown-glass scleral lenses. They covered the entire globe, had to be filled with a buffered saline solution, and could only be tolerated at best for three to four hours at a time.

In 1947 the first corneal contact lens was developed, and this evolved to the point where millions of individuals throughout the world have become more or less enthusiastic contact lens wearers in the past 38 years. The early PMMA "hard" or rigid contact lenses were very crude by today's standards, and those of us who fit them (largely on our wives or friends), had considerable misgivings as to what we were doing to the cornea. The lenses were large, thick, and fit flat so that the apex of the cornea rubbed on the back of the lens. This naturally caused severe adaptation symptoms, namely foreign body sensation and tearing, and it was only the most determined patient who could get through the two to three week adaptation period and achieve reasonable six to eight hour wearing time. We now know that the patients who did well with these early lenses developed corneal anesthesia and had a high pain threshold.

Largely through the impetus of optometry, which was quick to recognize a vast potential market, there was rapid improvement in lens design in the early 1950s. As new lathes and manufacturing techniques were developed, it became possible to make the lenses much smaller, thinner and steeper, thus reducing adaptation time to an acceptable seven to ten days, and increasing safe wearing time to a more realistic eight to 16 hours.

Doctor Davis is Emeritus Associate Clinical Professor of Ophthalmology, University of Wisconsin Medical School, Madison. Copyright 1985 by the State Medical Society of Wisconsin.

In 1960 a group of about 20 ophthalmologists, recognizing the need for more medically-oriented direction in the contact lens field, organized the Contact Lens Association of Ophthalmologists, a group that now numbers over 1600 members representing every state, who have been in the forefront of teaching and research in contact lenses for the past 25 years.

From 1950 to 1970 millions of patients were fit with "hard" PMMA lenses, largely for cosmetic purposes. The large majority of these patients were young myopic females. The primary visual indication for contact lenses was in the aphakic or postcataract population. Spectacle vision for these individuals is quite unsatisfactory with marked restriction in visual field and gross magnification. With a contact lens, normal vision is restored, and binocular vision in monocular aphakia becomes possible. Over this 20-year period, much was learned about the long-term corneal complication of contact lens wear, and the respiratory physiology of the cornea.

It became common to see corneal distortion, increasing astigmatism, and in rare instances peripheral corneal scarring or vascularization in the 10–20 year contact lens wearer. At first it was felt that these changes were primarily the result of mechanical pressure and irritation from the lens edge. However, it soon became apparent that chronic oxygen deprivation was the underlying cause. The cornea, being avascular, normally obtains the oxygen necessary for its metabolism from the air. PMMA is essentially impervious to oxygen, and when an 8–10 mm lens covers most of the corneal surface, the cornea must obtain its oxygen from the small amount that is dissolved in the tears that flow behind the contact lens. Some corneas withstand this decrease in oxygen better than others, and this is why some patients' corneas tolerate contact lenses only eight hours, while others can adapt to 16–18 hours of wear. In the old PMMA lenses, this adaptation and regular wearing time was critical. Every ophthalmologist and most family physicians are familiar with the 1:00 A.M. phone call from a contact lens wearer who has left his/her lenses in two to three hours longer than average, and now has all the symptoms of a corneal abrasion. This overwear syndrome, caused by acute oxygen deprivation, results in edema of the central corneal epithelial cells, and punctate keratitis. Fortunately, few of these cases went on to frank corneal abrasion, and corneal ulcers were extremely rare in the hard lens population.

All of this changed radically and permanently in 1970 when soft contact lenses first appeared in the United States, and the FDA entered the picture.

The first soft lens material was developed in Czechoslovakia, and Bausch and Lomb introduced soft lenses to an eager public in 1970. To their credit, Bausch and Lomb required any ophthalmologist or optometrist who wished to work with the lens to attend a one-day seminar in the care and fitting of the lenses. They also required a $5,000 investment in stock lenses, purchase agreements, and the like.

The FDA, worried about reports from England and Canada of infection with soft lenses, classified them as drugs and required any new soft lens material to undergo the same rigorous and expensive premarket testing as any new drug. This limited the introduction of competing soft lenses to those companies who could afford the several million dollars in development costs. When this restriction was lifted, many small companies entered the soft contact lens field, and there are now about 50 competing brands on the market.

In the first few years, the FDA insisted that the lenses be heat sterilized daily in freshly prepared saline solution, and this worked well with virtually no problems with infections or complications as long as the patient complied. The sterilization process was cumbersome and time-consuming, however, and patient compliance declined rapidly. We were soon seeing reports of pure culture of Pseudomonas organisms taken from dirty contact lens cases and saline bottles. This prompted the FDA to approve the use of preserved saline and cold chemical sterilization techniques, which were more effective but produced a high incidence (20% or more) of allergic conjunctivitis and superficial punctate keratitis in daily soft lens wearers.

The daily wear soft lens has many advantages over the PMMA hard lens. It is totally comfortable with no adaptation symptoms. It does not dislodge or become lost easily, making it an excellent athletic lens, and it rarely causes corneal edema or overwear syndrome. It is an excellent part-time wear lens as it does not distort the cornea, making it easy for the patient to switch back and forth between glasses and contacts. This was not true of PMMA hard lenses. The soft lens, however, is fit largely by trial and error, and requires little skill or training by the fitter. This fact opened Pandora's box to the intensely competitive, highly advertised situation we have today, with every type of chain store and discount optical house promoting and fitting soft contact lenses. While this practice has had the desired effect of reducing prices, it has been at the cost of many patients being fitted with lenses they did not need, or being improperly fitted, with poor patient instruction, and

very poor followup. All of this would not have been so bad if the lenses had continued on a daily-wear basis. The patient who developed allergic or infection problems with these lenses would simply stop wearing them and seek medical help, and there was rarely any irreversible corneal damage.

For some strange reason, many myopes are bothered by not being able to see clearly on awakening without taking the ten seconds to put on their glasses or the five minutes to insert their contacts, so there developed an increasing demand for a contact lens that could be left in overnight and worn for several days to several weeks at a time. These "extended wear" lenses had their first application in the aphakic patient with some justification and fair success. As the cataract patient ages, it becomes more difficult to insert, remove and care for a standard hard or daily-wear soft lens, and the patient is so handicapped with glasses that a soft contact lens that can be left in a week or more at a time is a real blessing. Since these were all postsurgical patients, virtually all of these early extended wear lenses were fit by, or under the close followup of, ophthalmologists or well-trained optometrists. Complications such as corneal edema, conjunctivitis, corneal vascularization, and the like, occurred but were promptly seen and treated. Problems arose when the FDA in its "wisdom" approved extended wear lenses for purely cosmetic purposes for the myopic population. The chain stores and discount centers promptly entered the market with intense advertising, and the manufacturers were only too glad to oblige as they doubled the price of these higher water content extended wear lenses.

All of the problems of inadequate instruction, care, and followup were now intensified as corneal edema and epithelial erosion became much more common with the cornea operating in a decreased oxygen environment for weeks at a time. The ever present Pseudomonas organism plus corneal abrasion equals a vision-threatening corneal ulcer.

The upshot of all this is that ophthalmologists are seeing an alarming increase in corneal ulcers secondary to extended wear soft contact lenses with many cases resulting in severe corneal scarring necessitating later corneal transplant and occasional perforation and loss of the globe. All this for the sake of not having to insert contact lenses in the morning!

The old PMMA material is now disappearing and is being replaced by new hard lens materials that are much more oxygen permeable than any prior lens, hard or soft. Since these lenses do not cover the entire cornea and provide an excellent oxygen environment to the cornea even through the closed lid, they will undoubtedly become the "extended wear" lens of the future.

The bottom line is that extended wear lenses should only be worn by those who have a real visual or occupational need for them, and should be fitted only under close supervision and follow-up by a well-trained optometric contact lens specialist or ophthalmologist. The patient must be very carefully instructed in the signs and symptoms of lens complication, and must have access to prompt medical eye care 24 hours a day, 365 days a year.■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

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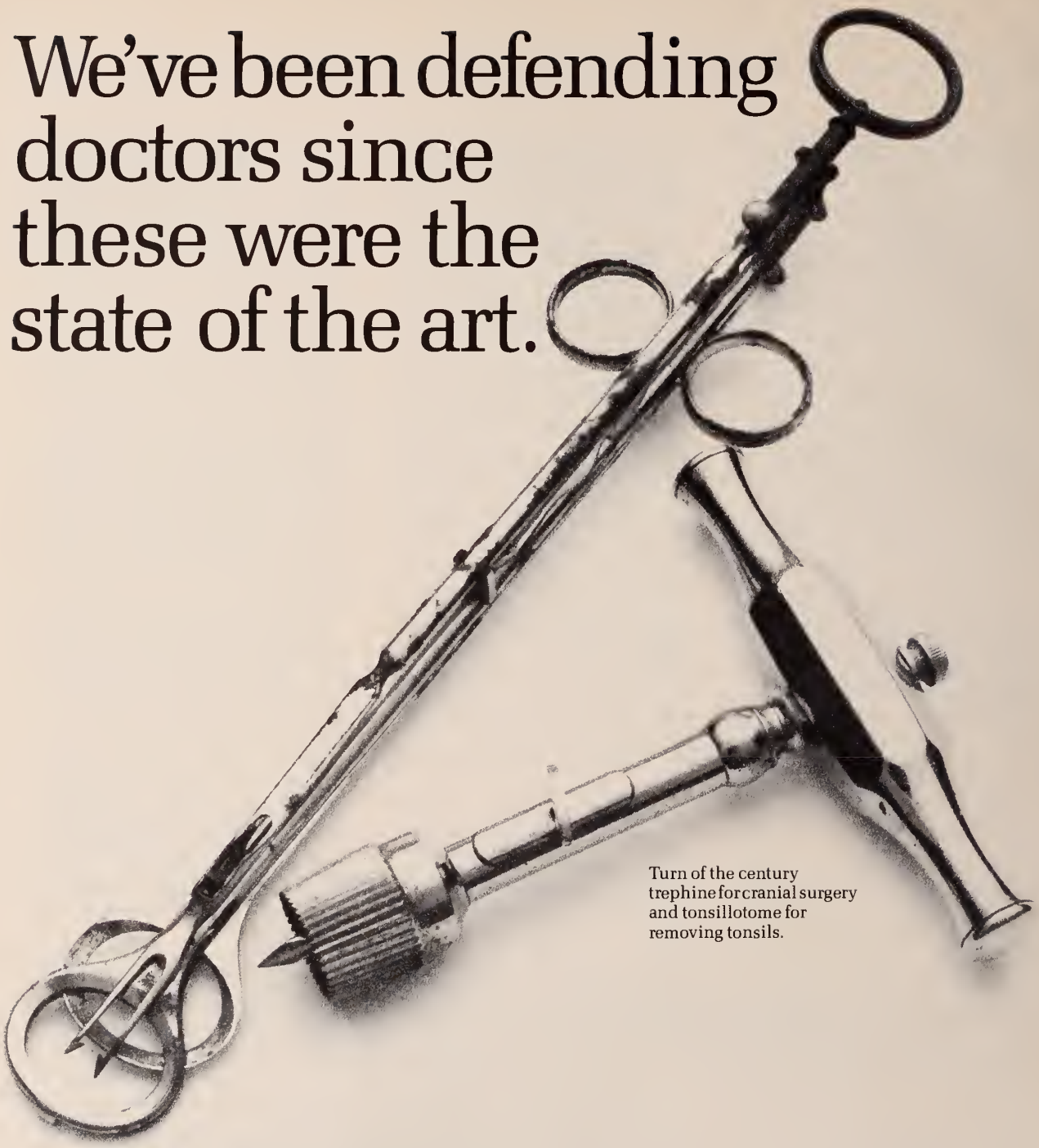

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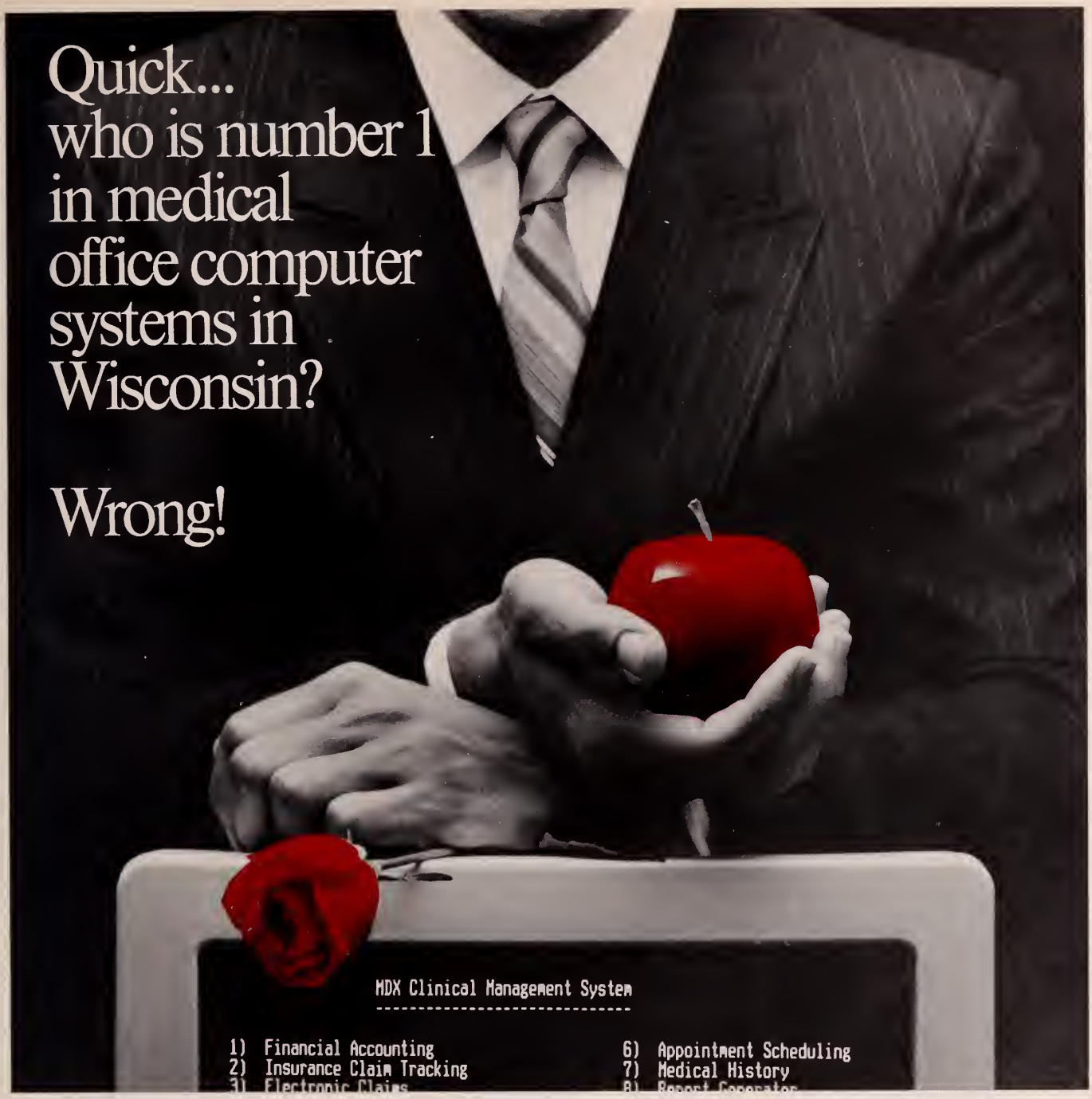

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Review of the clinical manifestations, laboratory findings, and complications of infectious mononucleosis

Lynn Rosen White, MD and *Peter S Karofsky, MD,* Madison, Wisconsin

ABSTRACT. ***Infectious mononucleosis is a viral illness with many clinical manifestations. The diagnosis is made in the laboratory using nonspecific tests like the white blood cell count and specific tests which measure antibody levels to the Epstein-Barr virus. Most patients with mononucleosis require only supportive treatment and recover without permanent mental or physical impairment.***

Key words: Mononucleosis; Infectious mononucleosis; Epstein-Barr virus

INFECTIOUS MONONUCLEOSIS (IM) is a disorder caused by infection of B-lymphocytes with Epstein-Barr virus (EBV). The diagnosis is based on many clinical manifestations including fever, lymphadenopathy, and pharyngitis. A lymphoproliferative response to the infecting agent produces many of the characteristic findings. The peripheral blood smear is characterized by a mild leukocytosis and a predominance of mononuclear cells of which at least 10-20% are atypical lymphocytes. All patients with IM will have an elevation in EBV-specific antibody titers, and most will demonstrate a positive heterophile antibody test.

From the Department of Pediatrics, University of Wisconsin Hospital and Clinics, Madison. Reprint requests to: Peter S Karofsky, MD, Dept of Pediatrics, H6/444, 600 Highland Ave, Madison, Wis 53792 (ph 608/263-8934). Copyright 1985 by the State Medical Society of Wisconsin.

Historical perspective. The clinical syndrome of fever, lymphoid hyperplasia, pharyngitis, and multisystem involvement in adolescents and young adults was first described as "Drusenfieber" (glandular fever) by Pfeiffer[1] in 1889. The specific clinical features of this syndrome were outlined by Sprunt and Evans[2] in 1920 and renamed "infectious mononucleosis." They also described "atypical lymphocytes" in the blood smear of patients with infectious mononucleosis. In 1923 Downey and McKinlay[3] further described these cells, naming them "virocytes" because of their association with other viral illnesses.

In 1932 Paul and Bunnell[4] published their work on heterophile antibodies in IM. Davidsohn,[5] in 1937, refined the laboratory diagnosis of IM with the recognition of differential absorption patterns of heterophile antibodies with bovine erythrocytes and with guinea pig kidney cells.

The virus cultured from lymphoblastic cells was discovered by Epstein, Barr, and Achong[6] during their studies of Burkitt's lymphoma. Using electron microscopy, they demonstrated the presence of a new herpes-like organism. Further study by Henle and Henle[7] in the 1960s led to a description of the Epstein-Barr virus and identification by new immunofluorescent antibody techniques of several antibodies to the virus. The antibodies were present in subjects with the infectious mononucleosis syndrome, and the association between EBV and IM was thus elicited by the Henles.[8]

Niederman, Pearson, and Miller[9] studied mechanisms of transmission of EBV. They showed nasopharyngeal and salivary shedding of the agent for prolonged periods following primary infection. Sixbey et al[10] demonstrated EBV replication in oropharyngeal epithelial cells from patients with IM. This study suggested the endogenous production of EBV as a source of reinfection of B cells.

Epidemiology. Epstein-Barr virus is ubiquitous. In developing countries EBV infection is generally asymptomatic and seropositivity is greater than 90% by early childhood. Symptomatic disease appears to be more common in industrialized countries where adolescents and young adults are most severely affected. In the more developed countries, seropositivity of greater than 90% is not achieved until age 30, and a higher prevalence of seropositivity among younger age groups in the lower socioeconomic groups is seen. Early acquisition of the viral agent in this population may be a result of crowded living conditions.

The salivary glands appear to be a major site of EBV latency and reactivation. Most patients with IM demonstrate oropharyngeal viral excretion intermittently for months following the acute phase of the disease. In many infected individuals viral excretion persists a lifetime.[10] It is postulated for groups with a high incidence of IM, such as young adults, that frequent, intimate oral contact via

kissing leads to transmission of EBV.[11] Infection also may be spread iatrogenically through blood products and bone marrow transplantation.

Pathophysiology. Infection of B-lymphocytes with EBV leads to transformation of the cells with subsequent intense proliferation. Infected B cells express cell surface membrane antigens capable of stimulating a suppressor-lytic T-cell response. The atypical lymphocytes associated with IM have been identified as activated T-lymphocytes.[12] Additionally, it is proposed that interferon released by infected B cells stimulates natural killer cell activity. These cell-mediated responses are probably responsible for the massive mononuclear infiltrates in various organs and tissues and may be causally related to the multisystem aberrations found in infectious mononucleosis.[13]

The acute phase of IM is characterized by the presence of a humoral response with production of anti-viral capsid (anti-VCA) IgM and IgG, which are detectable before the onset of symptoms, during the incubation period. These antibodies, along with the cell-mediated immune response, may curtail infected B-cell activity.

In convalescence, several specific antibodies develop, including anti-EBV nuclear antigen (anti-EBNA) antibodies and anti-early antigen (anti-EA) antibodies. Additionally, memory T-cells and helper T-cells monitor the antibody response. These activities are felt to be responsible for containing and preventing reactivation of latent EBV and for preventing the proliferation of potentially malignant EBV-transformed B-lymphoblasts.[15]

Deficient host responses to EBV infection can result in a chronic mononucleosis syndrome, which has been reported in individuals with hypogammaglobulinemia. In these patients there was persistence of abnormal EBV-specific etiologic response and clinical manifestations of recurrent pharyngitis, chronic malaise, and fatigue.[16,17]

The host also may respond with auto-antibody production which may be secondary to B-cell activation (polyclonal) or transient T-cell anergy. Activation of suppressor/cytotoxic T-cells (to control the polyclonal B-cell proliferation) also can effect transient suppression of cellular and humoral immunity and cause decreased immune responses to other concurrent infections and neoantigens.[13,18,19,20]

Clinical features. The familiar features of infectious mononucleosis can be thought of temporally in the sequence of prodrome, syndrome, and convalescence. Before the appearance of symptoms, a 30-50 day incubation precedes this sequence.[8] The prodrome generally lasts about 3-5 days and is characterized by fever, malaise, anorexia, myalgias, and headache. The syndrome follows over the next 5-15 days and may include exudative pharyngitis, tonsillar hypertrophy, palatal petechiae, cervical lymphadenopathy, periorbital and facial edema, conjunctival inflammation, exanthems, splenomegaly, and mild tender hepatomegaly.

The convalescent phase, which occurs from two to eight weeks after the onset of the illness is characterized by gradual resolution of the signs and symptoms. Periods of waxing and waning are not unusual.[21]

Typical laboratory findings during the acute phase of IM consist of the following: (1) white blood cell counts of 10,000-20,000/mm^3, (2) an absolute lymphocytosis (about 50% of total white blood cell count), and (3) atypical lymphocytosis (at least 10-20% of total white blood cell count). Transient neutropenia, anemia, and thrombocytopenia have been found early in the course of the illness.[22]

Abnormal liver function tests are common during the first three weeks of the disease and are indicative of a mild hepatitis. Values for liver enzymes such as serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, and lactic dehydrogenase are often two to three times normal. The bilirubin is mildly elevated to 1-3 mg/100 ml but is rarely greater than 5 mg/100 ml.[23] Although the abnormal liver function studies may persist for extended periods during the convalescent phase, it is unusual to see a persistent or chronic active hepatitis ensue.

One serologic test used to confirm the diagnosis of IM is the heterophile antibody test. Heterophile antibodies are IgM antibodies, which react with antigens, different from those which stimulated their production. Some heterophile antibodies cause agglutination of sheep red blood cells, while others are absorbed by guinea pig kidney cells or beef stroma. The Paul-Bunnell-Davidsohn test, of which the "spot" tests are variations, is based upon this principle. The heterophile antibody in mononucleosis patients is absorbed by beef red blood cells but not by guinea pig kidney cells. Heterophile antibody testing is done by diluting a serum sample sequentially by 50% to achieve dilutions of 1:8, 1:16, 1:32 . . . etc. Duplicate samples of the serial dilutions are then mixed with guinea pig kidney cells or beef red blood cells. The heterophile antibody (of IM), when present in the patient's serum, will be completely absorbed by beef red blood cells (stroma), but minimally absorbed by guinea pig kidney cells. Thus, an assay to detect the heterophile antibody *after* absorption by each of the above two reagents, in the case of a *positive* test, may show a

titer of at least 1:128, which is unchanged, or not decreased by more than one tube dilution following absorption with guinea pig kidney cells. It is markedly decreased, however, by absorption with beef red blood cells.[24] The term titer refers to the lowest serum concentration at which the antibody can be detected by the assay. Thus, the differential absorption pattern is a specific way in which the heterophile antibody concentration can be measured.

An example of a positive test is as follows: an adolescent with a three-week history of fever, malaise, pharyngitis, and lymphadenopathy is tested for heterophile antibodies. He has a titer of 1:256; the titer is unchanged after absorption with guinea pig kidney cells, but absorption to beef red blood cells yields a resultant titer of less than 1:8 (*ie,* undetectable even in relatively undiluted serum).

In most cases of infectious mononucleosis heterophile antibody tests will be positive by the end of the third week (85-90%).[23] In young children with IM heterophile antibodies are frequently negative. In the 10-24 month old group only 27% have a positive response. Seventy-six percent of the 26-48 month group have a positive response.[25]

Specific antibody testing is needed to establish the diagnosis of IM in cases where several features of IM are present and the patient has a negative initial and repeat heterophile test. The figure shows the temporal sequence of appearance of specific antibodies. Acutely, during the incubation period, there is a rise in titer of anti-viral capsid antigen (anti-VCA) IgM, which peaks during the acute phase, then diminishes rapidly over the next several months to undetectable levels. Anti-viral capsid antigen (anti-VCA) IgG titers also rise rapidly, paralleling the anti-VCA IgM titers during the late incubation and acute phases and will usually remain detectable for life.[14,26]

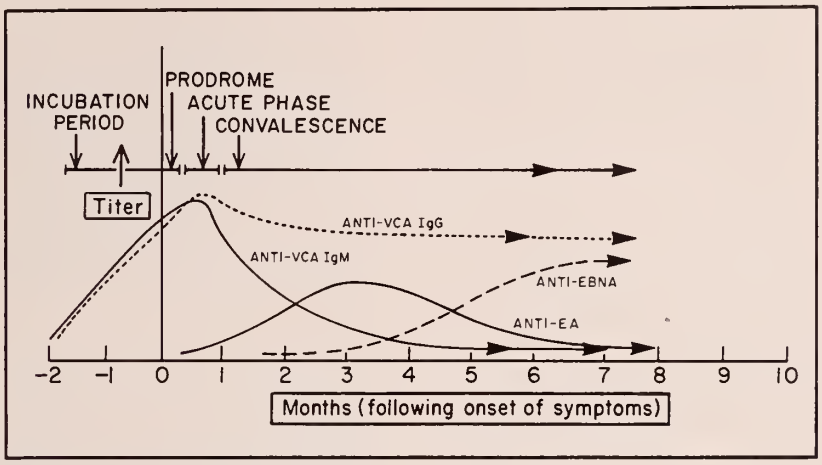

Figure 1—*Antibody profile in infectious mononucleosis.*

Approximately two to three weeks after the onset of the illness, anti-early antigen antibodies (anti-EA) appear. They rise in titer, and then decline slowly over several months. EA antibodies are present as diffuse (D) and restricted (R) components. Young patients are more likely to have an elevation of the restricted component, while older patients show a rise in the diffuse component.[25] Anti-EBV nuclear antigen (anti-EBNA) antibodies appear later in the convalescent period. These antibodies, like the anti-VCA IgG antibodies, persist and are detectable life-long[26] (Fig 1).

COMPLICATIONS. The complications of infectious mononucleosis described below by systems include severe and life-threatening sequelae of the syndrome as well as relatively unusual but reported effects associated with IM.

Ear, nose and throat. Airway obstruction secondary to marked lymphoid hyperplasia in IM is seen in both the younger and older age groups. Patients experiencing this complication have pharyngitis, often accompanied by a thick membranous exudate extending to the tonsils. They also have tonsillar hypertrophy, lymphoid hyperplasia in Waldeyer's ring (seen on lateral neck x-ray films) and cervical lymphadenopathy. These patients develop stridor and retractions and may progress to frank respiratory failure. Clinical improvement in some patients with obstruction of the upper respiratory tract secondary to lymphoid hyperplasia has been noted after the use of steroids.[27]

Concurrent infection with group A beta-streptococcus has been found in 3-30% of cases of IM; appropriate antibiotic therapy is recommended, with either penicillin or erythromycin for 10 days when cultures are positive.[28]

Peritonsillar abscess may present with signs and symptoms of peritonsillar swelling, purulent exudate, dysphagia, and trismus. Culture of abscess fluid (by aspiration) usually yields typical oropharyngeal and upper respiratory tract flora (streptococci, staphylococci, and sometimes anaerobes). In one series of patients hospitalized with IM, 1% developed peritonsillar abscess. Treatment modalities include needle aspiration, incision and drainage, and immediate tonsillectomy. Most treatment regimens also include systemic antibiotics.[29,30]

Reticuloendothelial system. Splenic enlargement caused by a mononuclear infiltration is a common finding in infectious mononucleosis. Patients often experience mild to moderate left upper quadrant discomfort and have an enlarged spleen on examination. Splenic rupture is a complication in 0.1-0.2% of cases with IM, with days 4-21 of clinical illness (following the prodrome) being the days of highest risk. Most ruptures are spontaneous but they may occur following palpation, bowel movements, or trauma. Ninety percent occur in males. The signs and symptoms include left upper quadrant pain, generalized pain in the entire abdomen, pain in the left shoulder, and increasing pain with inspiration. Hypovolemia may be present due to hemorrhage. A leukocytosis (white blood cell count of 15,000-30,000/mm^3) with a left shift also may be present. As physicians are generally adept at recognizing this entity, there have been no reported fatalities in the past 18 years due to this complication.[23]

Eye. Complications which involve the eye include conjunctivitis and Parinaud's oculoglandular syndrome. Another common feature of IM is periorbital (nonpitting) edema, referred to as Hoagland's sign.[31]

The type of conjunctivitis commonly seen in IM involves one or both eyes and may be a follicular or membranous inflammatory change. Conjunctivitis can occur during any stage of the illness, but it is most commonly seen during the acute phase.

The oculoglandular syndrome was first described by Parinaud[32] in 1889. This process consists of unilateral granular conjunctivitis, with preauricular and cervical lymphadenopathy on the ipsilateral side. The Epstein-Barr virus is one of many infectious agents that cause Parinaud's oculoglandular syndrome. The conjunctivitis can be severe and may be accompanied by nodular discrete lesions on the tarsal conjunctiva. The treatment of Parinaud's oculoglandular syndrome is generally symptomatic (warm soaks to the eyelids), but the granulations require excision. The specimens obtained from this procedure characteristically show large multinucleated immunoblasts.[32]

Cardiovascular. Myocarditis and pericarditis are rare complications of IM. The signs and symptoms include dyspnea, orthopnea, gallop rhythm, murmur, chest pain, and pericardial friction rub.

The electrocardiographic findings in myocarditis are T-wave inversions (V_4, V_5, V_6) and various patterns of block. In pericarditis nonspecific ST-T wave changes are seen.[33,34] Cardiac enzymes (creatine phosphokinase, lactic dehydrogenase, and serum glutamic oxaloacetic transaminase) may be elevated in acute myopericarditis.[34]

In cases of IM where heart disease leads to death, pathologic specimens demonstrate myofibrillar degeneration, interstitial edema, and lymphocytic infiltration.[35]

The treatment of heart disease depends upon the particular pathology and severity of the course. In severe cases of pericarditis, sedation, and analgesia, in addition to monitoring, are used. Supportive care in the case of myocarditis includes telemetry monitoring, inotropic regimens, and pacemaker placement (in cases of heart block). The use of steroids in the treatment of carditis has been advocated, following uncontrolled trials.[33] The results showed a dramatic improvement in signs, symptoms, and electrocardiographic findings within 48 hours of initiation of therapy.

Pulmonary. Pneumonia is another complication of IM. It is proposed that the temporary immunosuppression induced by EBV infection allows for super-infection with other organisms. Many patients with serologically proven EBV infection exhibit simultaneous infection with other known respiratory pathogens (viral, bacterial, and rickettsial).[36] There are no pathognomonic findings in the pneumonitis found in IM. Hilar lymphadenopathy, shifting infiltrates, strand-like parenchymal densities, and less frequently, pleural effusions and nodular densities may be present.

Pleuritis is also found in cases of IM with pneumonia. Whether this is due primarily to EBV infection is unclear.

Therapy for pleuritis and/or pneumonia is directed at the responsible pathogen.

Hematologic-oncologic. Severe hematologic complications in IM are rare. Anemia is not generally a part of the hematologic picture of IM, and when present should alert the physician to the presence of a more serious process. The acute onset of anemia suggests blood loss, most often secondary to splenic rupture. Hemolytic anemia is rarely severe and is present in almost 3% of patients.[23] Mechanisms proposed for the red blood cell hemolysis include anti-erythrocyte antibodies (IgG), anti-i cold agglutinins (IgM), and possibly, hypersplenism. The laboratory findings of hyperbilirubinemia associated with reticulocytosis will help to establish the diagnosis. Current therapy for severe hemolytic anemia includes red blood cell transfusions and the use of corticosteroids. Aplastic anemia associated with IM is thought to be secondary to aberrations in immunologic response of the host to EBV.[37]

Pancytopenia which follows a more insidious course may be seen in IM. In one study,[38] the mean time from onset of symptoms of pancytopenia to the nadir of cell counts was 21.3 days (range

7-49 days); the mean time from diagnosis of pancytopenia to bone marrow recovery was 6.25 days (range 4-8 days). In this report a patient with pancytopenia associated with IM recovered shortly after the initiation of steroid therapy. The immediate response of patients with pancytopenia to steroids gives credence to the hypothesis that this phenomenon may occur secondary to an immunologic reaction.

Decreased platelet and neutrophil counts have been observed in IM. Severe thrombocytopenia is rare and is thought to be autoimmune in nature.[23] Agranulocytosis is also a rare complication. In one report of two cases of agranulocytosis, the onset was noted two to six weeks after the onset of symptoms of IM.[39] Transient bone marrow suppression secondary to EBV infection may be responsible for the mild cases of agranulocytosis.

In addition to its association with IM, EBV has also been associated with a number of malignancies, including nasopharyngeal carcinoma, African Burkitt's lymphoma, some American Burkitt's lymphoma, and various poorly differentiated lymphomas. In the cases of Burkitt's lymphoma and nasopharyngeal carcinoma, it has been proposed that there is a long latent period between primary infection with EBV and detection of the malignancy. Specific antibody titers to EBV antigens are elevated with the appearance of these malignancies.[40,41,42]

Another form of a progressive, fatal lymphoproliferative disease, the X-linked lymphoproliferative syndrome, is thought to be a result of defective T-cell response to EBV-associated antigens.[43]

Neurologic and psychiatric. Neurologic complications secondary to IM are rare, occurring in fewer than 1% of cases. They occur at any time during the course of the illness. Any portion of the peripheral or central nervous system can be affected. Fatal outcomes have been reported with two neurologic complications, meningoencephalitis and Guillain-Barre syndrome with respiratory failure. Seizures have been reported in patients with IM who have meningoencephalitis and who have atypical lymphocytes in their cerebrospinal fluid.[44,45,46] Status epilepticus associated with meningoencephalitis is a potentially fatal entity.

Many psychopathologic entities, including cognitive disturbances, delirium, intellectual deterioriation (acutely), disorientation and various psychotic presentations including depression have been described during the course of EBV infections. Psychosis in the form of perceptual disturbances and visual hallucinations has been described as the "Alice in Wonderland" syndrome.[47] It is felt that many of these presentations are consistent with features of encephalitis, but they also may be the psychological responses of patients to the debilitation experienced with IM. Case reports describe a good response to conventional pharmacotherapy and psychotherapy in cases of acute psychosis.[48]

Cranial nerve pathology has been observed. Isolated cranial nerve palsies, particularly Bell's palsy, have been reported. A form of ophthalmoplegia associated with areflexia and ataxia has been described as a postviral acute polyneuritis syndrome in association with IM.[49]

Acute (reversible) bilateral and unilateral sensorineural hearing loss as well as vestibulitis have been described during acute EBV infection.[50,51]

Acute cerebellar ataxia in the form of pontocerebellitis can present as acute limb and truncal ataxia, incoordination, and dysarthria.

Other rare neurologic manifestations of IM include transverse myelitis and mononeuritis multiplex. The latter refers to inflammation of multiple isolated peripheral nerves.[52]

Integument. Rashes are a well-known feature of the acute phase of IM. Generalized eruptions are macular, maculopapular, urticarial, or petechial. A morbilliform rash is commonly seen following therapy with ampicillin during the acute phase of IM.

Papular acrodermatitis of childhood, or the Gianotti-Crosti syndrome, is manifested as a nonpruritic brown-red papular eruption of the face, buttocks, and extensor portions of the extremities. It affects children from age 6 months to 12 years most often. Although this is more commonly associated with hepatitis B, EBV also has been reported in association with this entity.[53]

Cold urticaria manifested by hives on areas exposed to cold air and cold surfaces or by ingestion of cold foods is seen in patients with IM. This reaction is thought to be a result of mast cell degranulation. It is not certain whether this occurs as a result of cold-activated factors (cryoglobulins and cryofibrinogens), but these were measured and were found to be variably elevated in patients with cold urticaria and IM. The cold-activated factors are thought to activate complement, which leads to the degranulation of mast cells.[54,55]

Cold-induced acrocyanosis is another example of skin involvement in IM mediated by immune factors. Distal extremity cyanosis in response to cold exposure can be the presenting phenomenon in IM. Cyanosis also can be observed on the lips, the tongue, and the nose. The proposed pathophysiology of this phenomenon is that agglutination of erythrocytes is caused by the activation of cold-

agglutinating autoantibodies, which are then fixed by complement.[56]

Gastrointestinal. Mild anicteric hepatitis is a common feature of IM. Liver function tests are transiently elevated during the acute phase of the disease and decrease to normal levels later in the acute and in the convalescent phases. Profound jaundice (with total bilirubin greater than 10 mg/100 ml) is very rare. The more serious complications of submassive hepatic necrosis and hepatic coma also are very unusual.[57] These latter entities may actually be due to a Reye's syndrome and not to the IM infiltrative process.

A transient malabsorption syndrome is observed in IM. Patients develop crampy abdominal pain, nausea, and vomiting and may become dehydrated.

Proctitis, another condition seen in association with IM, produces abdominal pain, tenesmus, bloody and mucoid rectal discharge, inguinal adenopathy, and rectal mucosal ulcerations.[58]

Pancreatitis is another feature of IM presenting as epigastric pain, nausea, and vomiting. Patients with pancreatitis have elevated serum lipase and serum amylase values (generally in the range of 100-600 units/dL).[58]

Miscellaneous complications. Genitourinary complications associated with IM are very rare. They include orchitis,[59] nephrosis,[60] and nephritis.[61,62]

Kawasaki-like[63] disease and Reye's syndrome[64] in association with IM have been described.

THERAPY. In most cases of uncomplicated IM supportive care is the only form of therapy required. Analgesics are the most common medications suggested for the discomfort experienced during the acute phase. Antipyretics may be given for the initial febrile course. Hydration is generally accomplished orally but may need to be administered parenterally in cases of dehydration following vomiting or in cases of severe dysphagia or odynophagia with pharyngitis and severe prostration.

Airway management is important, especially in the younger child with symptomatic IM who manifests airway compromise secondary to inflammation of pharyngeal, tonsillar, and lymph node tissues. It is current practice to attempt a short course of parenteral corticosteroids equivalent to 1-2 mg/kg (or 40-80 mg in young adults and adolescents) of prednisone on the first day, with rapid tapering over 5-12 days.[65] This is begun early in impending airway obstruction to avoid the necessity of intubation or tracheostomy. If airway obstruction is not relieved following the initial doses of corticosteroids, the patient will require an airway either via nasotracheal intubation or tracheostomy. Careful monitoring in an intensive care unit setting for such time as the acute swelling persists is generally advisable.

Activity level during acute disease and convalescence is an individual matter. In the past it was conventional practice to prescribe one to two weeks of bedrest during the acute phase. There is no basis for recommending bedrest in uncomplicated IM, since the symptomatic course usually abates within five to seven days.

Physicians limit activity in patients with IM because they are afraid of splenic rupture. In most patients with an enlarged spleen, mild activity, such as walking, is probably not harmful. Recommendations to athletes concerning resumption of athletics remains controversial. Maki and Reich[23] recommend that no athletics involving bodily contact should be attempted until splenomegaly and splenic discomfort resolve. Athletes involved in contact sports are asked not to participate in their sports for one month following the onset of illness. If the athletes do not have splenomegaly at that time, they may resume their sports. Whether an athlete has splenomegaly needs to be carefully documented. If the physical examination is negative or inconclusive, other examinations should be used to confirm a normal spleen size in the athlete who participates in contact sports. Diagnostic tests used include a flat plate of the abdomen, ultrasound, computerized axial tomography and spleen scan.[23] If there is evidence of splenic enlargement by these examinations, the tests should be repeated at one to two week intervals before resumption of contact sports activity can be advised. Stool softeners are sometimes prescribed for patients with IM to decrease straining, which also has been associated with splenic rupture.

The use of corticosteroid therapy in the routine management of IM is a controversial issue. The literature abounds with anecdotal evidence of the efficacy of early intervention with corticosteroids. These articles suggest using steroids for severe pharyngotonsillitis with potential airway obstruction,[27] for potentially fatal neurologic and for cardiac conditions. While there are no controlled studies of the effects of steroids on the course of IM, reports of rapid clinical improvement in patients with complicated infectious mononucleosis makes this an accepted form of therapy in the doses cited previously for treatment of impending airway obstruction. However, corticosteroids are not routinely recommended for patients with an uncomplicated course or for patients with mild complications.

SUMMARY. Infectious mononucleosis (IM) is a disorder caused by Epstein-Barr virus (EBV) infection of B-lymphocytes, which in turn produces lymphoproliferation, often accompanied by transient sup-

pression of cellular and humoral immune responses. The individual host response to infection with EBV determines the clinical expression of the disease. Generally, IM is a self-limited transient illness with potential multisystem involvement, presenting with fever, pharyngitis, and lymphadenopathy. While corticosteroids have been used to treat severe, life-threatening complications, in most cases of IM, therapy is largely supportive.

ACKNOWLEDGMENT: The authors wish to thank P Joan Chesney, MD for her review of the manuscript and Kathy Wolenac for her technical assistance and preparation of the manuscript.

REFERENCES 1-65 are available upon request to the authors.■

CLINICAL CANCER: Number 1 of a series

New discoveries in oncology:
Potential applications to clinical practice

Henry C Pitot, MD, PhD Madison, Wisconsin

This is the first of a regular series of articles on various topics on cancer. The series aims to offer brief and practical digests of current perceptions and management approaches to clinical cancer. The Professional Education Committee of the American Cancer Society aims in choosing topics to serve our audience of Wisconsin primary physicians. We expect to offer in coming months discussions of colorectal cancer screening, skin cancer, acute leukemia, mammography, chemoprevention, and comment on newest research advances as they may affect Wisconsin physicians. Because of the pithy nature of these articles, we especially want to encourage contact with the authors if you wish to discuss these topics further or obtain additional information. Your comments or suggestions for topics would be welcome.

Ernest C Borden, MD
Series Coordinator

From McArdle Laboratory for Cancer Research, University of Wisconsin Medical School, Madison. Reprint requests to: Henry C Pitot, MD, 1009A McArdle Cancer Research, UW-Madison Medical School, 450 N Randall Ave, Madison, Wis 53706 (ph 608/262-2177). Copyright 1985 by the State Medical Society of Wisconsin.

ALTHOUGH IT IS not the leading cause of death in developed countries throughout the world, cancer is the most feared disease in modern civilizations. Even in most undeveloped countries of the Third World, cancer is a leading cause of death in adults, with cancer of the stomach still exhibiting the highest worldwide incidence in the human population. In the United States the major fatal cancer in males is lung cancer, with 90% of the cases directly related to smoking habits. In the female, breast cancer still exceeds all other fatal cancers in incidence, although lung cancer has just overtaken breast cancer as the leading fatal cancer in women of the United States.

Few outside the medical profession realize the tremendous impact on our society of the morbidity of cancer, both in individual suffering and in tangible costs to this society. By a conservative estimate, the cost of cancer care in our society is in excess of $25 billion per year. Although individuals may have the legal right to increase their risk of developing cancer markedly through smoking, excessive drinking, and overeating, the claim that society does not have the right to regulate such excesses in order to protect the common good can hardly be justified.

Cancer prevention

More than 15 years ago the epidemiologic evidence strongly indicated that the majority of human cancers are directly related causally to environmental factors. Many governments, including that of the United States, sought to place more stringent controls on conditions of the workplace during the production of industrial chemicals and metals, as well as in the monitoring of the carcinogenicity of drugs produced by the pharmaceutical industry, in an attempt to eliminate potentially car-

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Physicians are encouraged to contact the authors if they wish to discuss these topics further or obtain additional information. Comments or suggestions for topics would be welcome.

cinogenic environmental factors. Almost all recent epidemiologic studies of occupational cancer indicate that industrial processes and specific chemical products may be directly related to significantly less than 5% of human cancers in our society. Moreover, there is now substantial evidence that 30% or more of potentially fatal cancers in our society result from the use and abuse of tobacco products for pleasure. Thus, the elimination of the tobacco habit in our society would decrease, within one or two decades, cancer mortality by more than one-fourth and the financial burden to our society by billions of dollars, not to mention the inestimable cost in human suffering.

A less well-defined, but still equally important environmental factor in the causation of human cancer is diet. Food additives, as well as artificial flavors and colors, probably contribute little if anything to the incidence of major human cancers, but dietary factors such as the overall composition of the diet and the amount consumed are important. Epidemiologic evidence that relates the fat content of the diet to specific human neoplasms (especially carcinoma of the breast, colon, and possibly several others) is now well-documented. The proportion of fiber, protein, and/or fat in the diet appears to be related to the increased incidence of colon cancer in several highly developed countries, although the mechanism is not completely understood. Stomach and esophageal cancer, which occur at very high incidences especially in South American and Eurasia, are undoubtedly related to dietary factors, some of which appear to be naturally occurring contaminants such as nitrosamines.

That some factors in the diet may actually protect against cancer has been shown both in experimental situations and in epidemiologic studies. Vegetables such as brussel sprouts, cauliflower, cabbage, and related plants appear to contain such protective factors. Whether specific vitamins and minerals, such as retinoids (vitamin A derivatives), vitamin C or E, and/or selenium, inhibit or prevent cancer development in the human remains to be proven, but their efficacy in cancer prevention in experimental animals is well-documented.

Until the last decade, the possibility of an infectious or biological cause of certain human cancers was considered at best remote. With the discovery of the causal relationship between hepatitis B viral infections and hepatomas, especially in underdeveloped countries; with the recent demonstration of the human T-cell lymphoma/leukemia virus (HTLV) in the Far East and the West Indies; and with the known causative association of the Epstein-Barr virus (EBV) with Burkitt's lymphoma and nasopharyngeal carcinoma, the viral causation of human cancer is now a significant environmental factor. Prevention in the form of vaccination is now feasible and under trial for the hepatitis B virus, so that successful worldwide vaccination, comparable to the smallpox vaccines, could potentially eliminate most hepatocellular carcinomas from the world. As yet, similar preventive actions for the HTLV, EBV, and human papilloma viruses (which may be causally related to neoplasms of squamous epithelium, including those of the uterine cervix, skin, esophagus, and rectum) have not been developed.

The third general causative environmental factor for human cancer is radiation. The control of sources of ionizing radiation in our society is relatively stringent, so that the principal source of radiation for the majority of our society is background radiation. Most of our society is exposed for varying periods to a major source of carcinogenic radiation, that of ultraviolet light. The incidence of melanomas of the skin has been on the increase in many Caucasian populations, including the United States, during the last several decades. It is quite likely that many of these lesions could be prevented by decreased exposure to sunlight and by protective measures taken during such exposures. Although epidermoid carcinoma of the skin is also related to exposure to sunlight for many years, the prognosis of these lesions is so excellent that these skin cancers are not even considered in most cancer statistical studies. On the other hand, malignant melanoma is potentially fatal in 30%–50% of affected patients.

The natural history of neoplastic development in relation to cancer prevention

The prevention of cancer is medically and sociologically clearly preferable to the treatment of cancer once established. Through our present knowledge of oncology, we could prevent more than 50% of human cancer in our society if our citizens and their physicians chose to undertake the needed preventive measures. That cancer prevention is not simply a theoretical possibility based on statistical and epidemiologic findings may be concluded from modern studies on the natural history of cancer development in the living organism. Today there is substantial evidence that most, if not all, cancers develop through a series of stages, the most well-defined of which are termed initiation, promotion, and progression.

The process of initiation alters a cell in some heritable manner so that a variety of agents—including cigarette smoke, diet, and internal hormones—may promote the development of identifiable neoplastic lesions within the host, such as carcinoma *in situ*, colonic polyps, mammary adenomas, and other premalignant lesions. From

such neoplasms malignant tumors develop during the stage of progression. Substantial evidence indicates that both the stages of initiation and progression involve irreversible genetic changes within the cell. The stage of tumor promotion, on the other hand, is a reversible process, which is usually effective in the formation of a malignant neoplasm from an initiated cell only when extended over a long period. Substantial evidence argues that the action of most, if not all, promoting agents is reversible; thus, interrupted or brief exposure to promoting agents probably represents little if any carcinogenic risk to the human. Since the major environmental factors involved in many human cancers in our society appear to involve the stage of tumor promotion (*eg,* tobacco smoke, diet, and hormones), cancer prevention by appropriate interruption of the stage of promotion could be a reality in the natural history of the development of many human cancers.

At the time of diagnosis, most clinically observed cancers are in the stage of progression. It is in this stage that the action of "oncogenes" appears to predominate. Oncogenes, first described in cancer-causing viruses, have homologues in normal cells which are termed proto-oncogenes. In normal tissue, expression of proto-oncogenes is low and is controlled by normal cellular function. In cancer cells not infected by oncogenic viruses, one or more of these genes may be expressed at an extremely high level, and substantial evidence indicates that this expression is related directly to the relatively uncontrolled growth of the cancer cell. Theoretically possible techniques now being carefully investigated may allow the specific targeting of agents to the products of oncogenes in cancer cells, thereby inhibiting the uncontrolled action of these originally normal genes.

Newer developments in early diagnosis and treatment of cancer

Little need be said here about the revolution in electronic and computer technology that has led to sophisticated and refined, albeit expensive, diagnostic techniques useful in the detection and management of cancer in the human. These include computer-assisted tomography, nuclear magnetic resonance, and other related technologies. The continued trials of drug combinations have led to significant, even striking, improvements in the remission and cure of a variety of human cancers. Some neoplasms, such as acute lymphoblastic leukemia in children and Hodgkin's disease in both children and adults, have responded dramatically to multiple drug chemotherapy with and without radiation treatment. Although such treatment is not without some small risk of future cancer, the benefit to the patient by the elimination of the fatal disease being treated is unquestionably great. Unfortunately, major killers such as lung, breast, prostate, and colon cancer have not yet responded in a similar fashion to drug therapy, although combination chemotherapy has resulted in prolonging the lives of many patients. Moreover, several studies indicate that the rigorous application of multiple drug therapeutic regimens by all physicians could result in a marked increase in remission of such neoplasms, even leading to cures in a number of cases.

From the research viewpoint, an even more exciting avenue of therapy is still largely in the laboratory. A series of agents have been shown to induce cancer cells to differentiate into their essentially normal counterparts; many times such differentiation is terminal, in that the cells can no longer divide. Only in the last couple of years have any of these agents been tried in patients, although their efficacy in tissue culture and in a few animal systems has been known for more than a decade. Some agents, such as synthetic retinoids, may not only induce such differentiation, but may actually prevent the formation of cancers, probably by inhibiting the stage of tumor promotion. It is hoped that such agents will be employed successfully in the clinic within the next decade.

Cancer: tomorrow and the future

Our knowledge of human cancer—its statistics, epidemiologic characteristics, and pathogenesis—is increasing at an exponential rate. Recent knowledge is forcing consideration and application of newer methods of prevention and therapy of this scourge of humanity. The physician who treats cancer has a responsibility to his or her patients to keep abreast of developments in the field of oncology that can be applied in practice. If cancer in our society is ultimately to be controlled by prevention, early diagnosis, and modern treatment, it is the physician and the patient who ultimately hold the key to such control.

Bibliography

The basis for this short essay is the third edition of the textbook, "Fundamentals of Oncology," which will be published in December 1985 by Marcel Dekker Inc, New York. The reader interested in more detailed considerations of the points raised here may wish to refer to this text.■

American Physicians Life's comprehensive and competitively priced line of insurance products is now being offered exclusively through SMS Services Inc., to State Medical Society members.

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Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1986 are $455 for SMS, $375 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. • ***First year in practice***—physicians elected to SMS membership within six months of completing residency, fellowship, or fulfillment of government obligation enjoy a dues reduction of 50 percent for the first year. • ***Second year in practice***—physicians who quality by meeting the above criteria enjoy a 25 percent dues reduction during their second year of practice. • ***Two-physician family***—one member (spouse) of a two-physician family is entitled to a dues reduction of $50 or the amount of their State Society dues whichever is less.

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1986 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$455.00	$375.00	Normal County Dues
1st Year in Practice	$227.50	$187.00	Normal County Dues
2nd Year in Practice	$341.25	$281.00	Normal County Dues
Two Physician Family	$405.00	$375.00	Normal County Dues
Part-Time Practice	$227.50	$375.00/-0-*	Normal County Dues
Part-Time—Over Age 70	$227.50	$187.00*	Normal County Dues
Resident	$ 45.50	$ 45.00	Varies
Military Service	-0-	$250.00/$ 45.00	-0-
Associate	-0-	-0-	-0-
Retired	-0-	$375.00/-0-*	-0-
Retired—Over Age 70	-0-	-0-	-0-
Life	-0-	$375.00/-0-*	-0-
Honorary	-0-	$375.00/-0-*	-0-
Over Age 70	$227.50	$375.00/-0-*	Normal County Dues
Candidate—			
Freshman Year Medical Student	-0-	$ 20.00	Varies
Sophomore and Succeeding Medical Student Years	$ 10.00	$ 20.00	Varies
Postgraduate—One	$ 10.00	$ 45.00	Varies
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-

*Physicians in these categories may be eligible for exemption from paying AMA dues under the grandfather clause:

AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria, with the exception of financial hardship or disability, will automatically be dues-exempt in 1986 and beyond under the grandfather clause.

Under new AMA policy, only the following two categories of physicians will qualify for new dues exemption:

(1) Financial hardship and/or disability.
(2) 70 years of age or older *and* fully retired.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

Your membership in organized medicine will help insure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1986 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

SMS membership reaches new high

Record numbers of physicians have joined SMS and their county medical societies in 1985. Since January 1, 1985, nearly 900 new members have been elected to membership. By mid-November total SMS membership had reached 6,472, an increase of 12.5% over 1984 levels.

The largest single increase was in the category of full-dues paying members, which rose 13.2% to an all-time high of 5,143 physicians. Other membership classifications posted lesser gains. Candidate membership (students and post-graduate-1s) rose to 452, an increase of 3.2% over 1984 levels, while the number of dues-exempt physicians (life member, military service, retired, etc) increased 11.2%

Two key factors have contributed to the surge in SMS membership, according to SMS Director of Membership and Communications Ron Henrichs.

The first is the availability of The Professionals Medical Liability Insurance Plan through SMS Services, Inc, the for-profit subsidiary of the State Medical Society. Offered to SMS member physicians only, this program offers competitively-priced professional liability insurance with a number of attractive features. As of mid-November, more than 2,858 Wisconsin physicians had opted for coverage through this program.

The second factor mentioned frequently by new members is the awareness and recognition of organized medicine as an outspoken advocate for Wisconsin physicians and their patients. In 1985, SMS and county medical societies mounted an aggressive membership development program that focused on physician advocacy and representation as well as tangible membership benefits.

While state and county society memberships have shown substantial gains, AMA membership has continued to decline. Only 4,498, or slightly less than 70%, of SMS members currently belong to the AMA.

SMS President John K Scott, MD has expressed his serious concern about the decline. According to Doctor Scott, "AMA membership is absolutely essential for every Wisconsin physician. Continued, broad-based physician support for organized medicine at all levels is critical to meeting medicine's challenges today and in the future."■

H/D Nominating Committee selects slate of candidates

Meeting upon conclusion of the Leadership Conference, October 26, in Appleton, the House of Delegates Nominating Committee selected the following slate of candidates for positions to be filled by House elections at the 1986 Annual Meeting in April:

President of the Society for 1986-87: John P Mullooly, MD, Milwaukee

President-elect for 1986-87: Kenneth M Viste Jr, MD, Oshkosh

Treasurer for 1986-87: John J Foley, MD, Menomonee Falls, to succeed himself

Vice Speaker of the House of Delegates for 1986-88: Vernon M Griffin, MD, Mauston, to succeed himself

AMA Delegates for calendar years 1987 and 1988 to succeed themselves: John K Scott, MD, Madison; Patricia J Stuff, MD, Bonduel; and DeLore Williams, MD, West Allis

AMA Alternate Delegates for calendar years 1987 and 1988 to succeed themselves: Cyril M Hetsko, MD, Madison; John P Mullooly, MD, Milwaukee; and John D Riesch, MD, Menomonee Falls.

Biographical sketches of these candidates, with pictures, will appear in the January issue.■

President-elect Landis will not serve office

Chairman Darold A Treffert, MD, Fond du Lac, announced at the October 25 Board of Directors meeting in Appleton that Charles W Landis, MD, Milwaukee, will not serve, for health reasons, as the Society's president when his term is scheduled to begin in April.

Doctor Landis will continue to serve on the management advisory committee charged with filling the secretary-general manager's position in 1987.

John P Mullooly, MD, Milwaukee, was named as an additional member of the advisory committee.

Doctor Mullooly, the following day, was nominated by the First District as a candidate to fill the office of president for the 1986-87 year.■

John K Scott, MD

1985 Leadership Conference

The future of medicine—prognosis, perspectives and prescriptions

October 25–26/Appleton

Program participants:

Anthony S Earl, Governor of Wisconsin. Special guest at reception.

James S Haney, President, Wisconsin Association of Manufacturers and Commerce. Topic: *Wisconsin's economic health.*

John K Scott, MD, President, State Medical Society of Wisconsin. *Opening remarks.*

Jerald R Schenken, MD, Omaha, Trustee, American Medical Association. *Opening remarks.*

Uwe E Reinhardt, PhD, Professor, Department of Economics, Princeton University. Topic: *Health care: An economist's view.* Discussion facilitator: Darold A Treffert, MD, Fond du Lac, Chairman, SMS Board of Directors.

David Carley, Carley Capital Group, Madison and Washington, DC. Topic: *Health care: A businessman's view.* Discussion facilitator: Timothy T Flaherty, MD, Neenah, SMS Past President.

Mark Yessian, Deputy Regional Inspector General, US Department of Health and Human Services, Boston. Topic: *Fraud and abuse: A federal view.* Discussion facilitator: Henry F Twelmeyer, MD, Elm Grove, Chairman, SMS Health Care Data Task Force.

Susan F Behrens, MD, Beloit, Chairman, Wisconsin Medical Examining Board. Topic: *The State as 'public protector.'* Discussion facilitator: Robert E Johnston, MD, Green Bay, Chairman, SMS Mediation and Peer Review Commission.

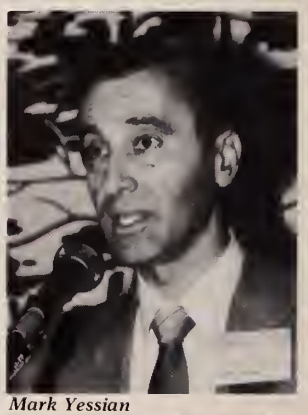
Kenneth J Wagstaff, Executive Director, Board of Medical Quality Assurance, State of California, Sacramento. Topic: *Review and discipline: A new look.* Discussion facilitator: Roger L von Heimburg, MD, Green Bay, Vice Chairman, SMS Board of Directors. ■

Photos by Ben Bartel

Uwe E Reinhardt, PhD

Jerald R Schenken, MD

Anthony S Earl



Mark Yessian

Kenneth J Wagstaff

David Carley

Susan F Behrens, MD

James S Haney

Governor Earl addresses SMS Leadership Conference

Sounding a sympathetic note to the plight of physicians and other professions and industries experiencing escalating insurance premium costs, Gov Anthony S Earl opened the State Medical Society of Wisconsin's 1985 Leadership Conference October 25 in Appleton.

The Governor noted that while limits on malpractice awards are a partial solution, there must be a greater effort on the part of both physicians and attorneys to police, discipline, and review their own ranks.

Governor Earl's brief remarks came at the conclusion of a reception during which several of the 125 SMS leadership physicians and spouses attending the weekend-long event had the opportunity to speak with him, expressing their concerns over the current malpractice "crisis" and other issues in the field of medicine.

His call for more effective discipline was echoed by numerous speakers throughout the course of the conference, including the SMS Board of Directors which earlier in the day voted unanimously to report to the State Medical Examining Board the questionable practices of a state physician. The decision, only the second one of its kind in the past five years, was based on research conducted over the course of the past 12 months into the physician's practice.

That type of demonstrable concern for the profession also was urged later in the conference by MEB chairman Dr Susan F Behrens, Beloit. Doctor Behrens told physicians there is a growing need for concerned, competent members of their ranks to step forward to volunteer to help review the backlog of cases the MEB currently faces and the growing number of cases it expects to receive in the months ahead. A new peer review mechanism overseen by the MEB appears to be the most acceptable answer to the backlog, she said.

Doctor Behrens' talk was the subject of a story in the Sunday, October 27 edition of *The Milwaukee Journal* in which a new series of potential penalties against malpracticing physicians was catalogued.

Those include: requiring physicians to take additional training; levying fines against them; requiring doctors to refund patient fees and to pay damage costs; and establishing a conflict resolution system involving the patient, the physician in question and the State Department of Regulation and Licensing.

The Department invited the public's comments on those options during a November telephone survey.

The broader range of disciplinary options would be a step toward correcting the current situation the Board faces in closing about 87 percent of the cases brought to it without taking any action against the physicians, Doctor Behrens said.

Additions to the MEB's legal and investigative staffs are expected to help but not fully alleviate the 386-case backlog.

Transcribed versions of Doctor Behrens' presentation and of other conference participants' talks will be developed within the next several weeks. A synopsis of them will appear in a future edition of *Medigram* and in the *Wisconsin Medical Journal.*■

Dr Treffert named to statewide professional discipline task force

The State Medical Society's chairman of the Board of Directors, Darold A Treffert, MD, Fond du Lac, in early November was named to a statewide panel charged with reviewing the State Department of Regulation and Licensing's entire system of professional review and discipline.

Governor Anthony S Earl established by executive order the Governor's Task Force on Professional and Occupational Discipline. Its charge is to determine whether the state's disciplinary procedures of professions and occupations are adequate.

Chaired by Dane County District Attorney Hal Harlowe, the task force will report to the Governor by next July 31.

Emmanuel Scarbrough, a University of Wisconsin-Madison medical researcher, also was named to the panel.

Doctor Treffert also is a past president of the State Medical Society.■

Leadership Conference participants (left to right): John K Scott, MD, President, State Medical Society; James S Haney, President, Wisconsin Association of Manufacturers and Commerce; Mrs (Louise) Scott; and Anthony S Earl, Governor of Wisconsin.

Max Goodwin Physician-Citizen of the Year

Max H Goodwin, MD, Two Rivers, was honored November 20 as the 1985 Physician-Citizen of the Year.

It is an award that has been presented since 1982 by the SMS and the Wisconsin Chamber of Commerce Executives Association.

SMS President John K Scott, MD, presented the plaque at a luncheon in Doctor Goodwin's honor in Manitowoc.

Doctor Goodwin was chosen on the basis of his civic involvement in the Manitowoc-Two Rivers community since his arrival there in 1978. Among the criteria used in making the selection were his contributions to both the community and the nation, to the public understanding of the role of medicine, and to the better health and improved quality of life for Wisconsin patients.

Doctor Goodwin provided three years of successful leadership for the Fox Valley Family Practice Residency program that concluded this past June. He also served as medical director for the development of the "Fit for Life" wellness program designed for Hamilton Industries, Two Rivers. The program is now available to physicians across the state and country.

As a member of the Two Rivers Community Hospital's joint venture committee, Doctor Goodwin has taken an active role in ensuring the institution's restructuring would position it as a longstanding component in the community's healthcare delivery system.

He also is a member of the executive board of the Community Choice Health Maintenance Organization which is a joint venture between the Manitowoc and Marshfield clinics.

Doctor Goodwin's community involvement also includes a number of civic organizations: Compassionate Friends, board of directors; Good Shepard Lutheran Church, financial secretary, directing council and choir; Lake Shore Chapter, Lutherans for Life, medical advisor; Two Rivers-Mishicot United Way, past member, board of directors; Two Rivers Community Hospital, executive committee, vice chief of staff, medical audit committee and joint conference on long-range planning.

John Zeldenrust, MD, President of the Manitowoc County Medical Society, was master of ceremonies for the luncheon honoring Doctor Goodwin.■

Senior physicians elect

The Wisconsin Association of Senior Physicians (WASP), at its November 9 annual meeting held in Madison, elected the following physicians to office for the year 1986:

Stanley W Hollenbeck, MD,*
Appleton—president
Carroll A Bauer, MD,*
Phillips—secretary-treasurer
Palmer R Kundert, MD,*
Madison—president-elect.

Other events of the meeting were published in the November issue.■

Annual Meeting resolution deadline

The 1986 House of Delegates sessions will be held April 18-19 in Milwaukee. All resolutions must be submitted in proper form to the Secretary's office at SMS no later than February 18, 1986 (two months prior to the first session of the House). It is important that county medical societies, specialty sections, and members submit resolutions early to facilitate early distribution of materials and allow all delegates to adequately represent their county medical society or specialty section. If a resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS staff is available to assist in preparation of fiscal notes. The first session of the House will convene on April 18 and the second and third sessions will be on April 19, 1986.■

Left to right: John K Scott, MD, Madison, president of the State Medical Society, with the 1985 Physician-citizen of the Year award recipient Max H Goodwin, MD, Two Rivers; along with his wife, Mrs (Judith) Goodwin; John C Zeldenrust, MD, president of the Manitowoc County Medical Society; and Betty Bullock, executive vice president, Fort Atkinson Chamber of Commerce, and member of the Award selection committee. (SMS Staff photo by Ron Henrichs)

BALANCED CALCIUM CHANNEL BLOCKADE!

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

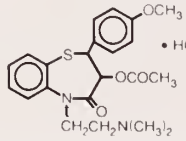
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1985 Membership Directory as published in the July 1985 issue of the *Wisconsin Medical Journal*. Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership records. County transfers will be included when processing has been completed by the Membership Department.

Changes in practice specialties (as used by the AMA) and changes in **Board-certified specialties** as listed by the American Board of Medical Specialties.

(changes only with member's name; practice specialties appear before the slash (/) and Board-certified specialties appear after the slash.)

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State Medical Society Legislative Status Report

Bills approved by both Houses

Bill	*SMS Position*	*Status*
AB 85 (Hospital Rate-Setting Commission—HRSC): Retains the HRSC, but exempts from rate-setting those hospitals with annual revenues less than $10 million if the rate increase is less than the hospital market basket and consumer price indexes. Sunsets HRSC July 1, 1987. Requires a Legislative Council Study on rate-setting with recommendations due January 1, 1987.	Support repeal of HRSC	Law, 1985 Wisconsin Act 29
AB 85 (Capital Expenditure Review—CER): Increases the threshold amount for reviewable projects from $600,000 to $1,000,000 ($1,500,000 for hospital conversions and renovation). Reviews for expansion of services are limited to transplant programs, burn centers, neonatal intensive care programs, cardiac programs, air transport services, and the addition of psychiatric or chemical dependency beds. Places a 3-year moratorium on new hospital beds. Sunsets CER program July 1, 1989.	Support repeal of CER.	Law, 1985 Wisconsin Act 29
AB 85 (Mandated Mental Health Benefit): Increases required insurance coverage for outpatient mental health and AODA treatment from $500 to $1,000 and requires inpatient coverage to include the lesser of 30 days or $7,000. Provides that psychiatrists and psychologists are eligible for the insurance reimbursement, thus exempting them from current "certified clinic" standards. Places a moratorium on new outpatient clinics. Requires a study on the mandated coverage.	Mixed	Law, 1985 Wisconsin Act 29
AB 85 (Health Care for Uninsured): Requires DHSS to develop pilot projects in three geographical areas to provide health coverage to low-income, uninsured persons and subjects the plans to Joint Committee on Finance for approval. Provides funding for Primary Care Program (modeled on the ShareCare Program) to continue health care services in areas of high unemployment.	Support	Law, 1985 Wisconsin Act 29
AB 85 (Graduate Medical Education—GME): Provides for a study to develop proposals on funding GME in Wisconsin.	Monitored	Law, 1985 Wisconsin Act 29
AB 85 (Medical Liability Reporting): Effective February 15, 1986, and thereafter, requires medical malpractice insurers and the Patients Compensation Fund to report monthly to the Medical Examining Board on claims paid the previous month for damages arising out of the rendering of health care services by a provider.	Support	Law, 1985 Wisconsin Act 29
AB 85 (Chiropractic Coverage): Mandates a minimum coverage of 28 chiropractic visits per year in health insurance contracts, HMOs, and PPOs.	Oppose	Vetoed
AB 471 (Capital Expenditure Review—CER): Changes the effective date of the increased threshold amounts for reviewable projects enacted by the budget bill (AB 85) from July 1, 1986, to January 1, 1986. Makes minor modifications to laws relating to forfeitures for project cost overruns, financing for projects, and hospital acquisitions by another hospital.	Support	Law, 1985 Wisconsin Act 72

State Medical Society Legislative Status Report/*continued*

Bill	*SMS Position*	*Status*
AB 487 (AIDS): Modifies language enacted by the budget bill (AB 85) to authorize disclosure of HTLV-III antibody test results to the person's health care provider, their employers or agents involved in patient care or in handling or processing specimens or bodily fluids or tissues. Positive test results are reportable to the state epidemiologist.	Support	Law, 1985 Wisconsin Act 73
SB 134 (FAS Pamphlets): Requires county clerks to distribute pamphlets describing the causes and effects of fetal alcohol syndrome to persons issued marriage licenses.	Support	Law, 1985 Wisconsin Act 19
SB 219 (Pituitary Gland Removal): Authorizes a coroner's physician or medical examiner to remove the pituitary gland at a lawfully performed autopsy and transmit to the National Hormone and Pituitary Program.	Support	Law, 1985 Wisconsin Act 93
AB 481 (Minor Bone Marrow Donation): Establishes a consent procedure under which a minor may donate bone marrow to a brother or sister.	Support	Law, 1985 Wisconsin Act 50
Pending Legislation		
SB 7 (Seat Belts): Requires use of seat belts in motor vehicles required by law to be so equipped. (Three identical Assembly Bills are also pending.)	Support	Endorsed by Transportation Committee, available for floor action
SB 87 (Drug Paraphernalia): Restricts the sale, use, possession, and advertising of drug paraphernalia.	Support	In Senate Judiciary & Consumer Affairs Committee
SB 195 (Drinking Age): Increases minimum age for procurement, possession, and consumption of alcoholic beverages from 19 to 21.	Support	In Labor, Business, Veterans Affairs & Insurance Cmte.
SB 281 (Reporting Birth Defects or Disabilities): Creates a Birth and Developmental Outcome Monitoring Program within DHSS. Physicians are required to report to the Department birth defects or developmental disability within 30 days of a suspected, confirmed, or updated diagnosis in children up to age six.	Oppose	Endorsed by Agriculture, Health & Human Services Committee. In Joint Finance Cmte.
SB 283 (Sickle Cell Disease): Requires infant testing for sickle cell disease and creates a technical council on biochemical screening.	Oppose	In Agriculture, Health & Human Services Committee. (Public hearing held)
SB 285 (Pharmacy Practice): Authorizes pharmacists to monitor, initiate, administer, or modify drug therapy in accordance with written protocols between a pharmacist and practitioner. SB 285 is a repeal and recreation of the pharmacy statutes.	Oppose	Provision deleted by amendment; remainder of bill passed by Senate. In Assembly Commerce & Consumer Affairs Cmte.

State Medical Society Legislative Status Report/*continued*

Bill	*SMS Position*	*Status*
SB 320 (Smoking-Induced Diseases): Authorizes a family member of a person who dies as a result of cigarette-induced lung cancer or emphysema to bring a wrongful death action against a cigarette producer.	Monitor	In Judiciary & Consumer Affairs Committee. (Public hearing held)
SB 328 (Medical Malpractice Reforms): Makes various changes in the laws governing medical malpractice proceedings including placing a $3.3 million limitation on awards. *(SMS has a position to limit awards for non-medical expenses to $1 million, with no limits on awards for future medical expenses.)	*Support	In Labor, Business, Veterans Affairs & Insurance Committee. (Public hearing held)
SB 345 (Regulation and Licensing): Makes various changes within the Department of Regulation and Licensing including requiring 50% public membership on all examining boards, authorizing the Department to commence or close disciplinary proceedings without examining board approval, and authorizing the Department to appeal examining board decisions.	Oppose in part	In Senate Judiciary & Consumer Affairs Committee
SB 350 (Involuntary Commitment): Creates additional standards for involuntary mental commitment.	Support	In Senate Judiciary & Consumer Affairs Committee
SB 369 (Midwives): Directs the Department of Regulation and Licensing to license as a midwife any person who is at least 18 years old, is a high school graduate or equivalent, meets certain practice requirements and educational prerequisites, and passes an examination.	Oppose	In Senate Health & Human Services Committee (Public hearing held)
SB 372 (CME): Eliminates the biennial continuing medical education requirements for physicians.	Oppose	In Senate Agriculture, Health & Human Services Committee
SB 388 (Required Request for Organ Donation): Requires hospitals to establish a system of requesting consent of family members for organ donation when a deceased patient is a suitable donor.	Support	Passed Senate In Assembly Health Committee
AB 76 (Involuntary Commitment): Makes a number of procedural modifications to involuntary commitment law.	Support	Passed Assembly In Agriculture, Health & Human Services Committee
AB 196 (Cigarette Sale to Minors): Prohibits the sale of tobacco products to minors.	Support	Endorsed by Health Committee In Joint Finance Committee

State Medical Society Legislative Status Report/*continued*

Bill	*SMS Position*	*Status*
AB 246 (Overdue Insurance Claims): Waives insurance company interest payments on overdue claims if the amount of interest due is less than $5. Also, extends time limit before a claim is overdue from 30 days to 30 business days.	Oppose	Defeated in Financial Institutions & Insurance Committee
AB 252 (Living Wills): Repeals the standard that death must occur within 30 days before a living will is effective and replaces it with a standard that death must be imminent. Modifies the prohibition against withholding nutritional support and fluid maintenance to prohibit it only when necessary to maintain the comfort of the dying patient. (The latter provision was defeated by the Assembly, so the bill reverts to the strict prohibition in current law.)	Support	Passed Assembly In Senate Judiciary & Consumer Affairs Committee
AB 256 (PT Practice): Authorizes physical therapists to evaluate and treat patients without the referral from a physician, dentist, or podiatrist. (Companion bill, SB 233, is currently pending in Senate Agriculture, Health & Human Services Committee.)	Oppose	Endorsed by Assembly Health Committee. Available for floor action.
AB 311 (Mental Commitment): Creates an additional standard for involuntary mental health commitment based on a patient's need for treatment and, because of the mental illness, inability to reach an informed decision concerning treatment. All current due process is maintained.	Support	In Judiciary Committee (Public hearing held)
AB 344 (Chiropractic Coverage): Mandates chiropractic services in health insurance contracts, HMOs, and PPOs.	Oppose	In Financial Institutions & Insurance Committee
AB 361 (Local Aid for Public Health): Provides funding of up to $3 per resident to local governments to assist public health services.	Support	In Health Committee
AB 470 (Respiratory Therapists): Provides for the certification of respiratory care practitioners by the Medical Examining Board and requires such certification to practice enumerated respiratory care procedures.	Support	In Commerce & Consumer Affairs Committee

AIDS bill becomes law

Assembly Bill 487, dealing with provisions for HTLV-III antibody testing, was adopted in the fall session of the 1985 Legislature.

This legislation was sought by the State Medical Society, blood banks, the State Division of Health, insurers, and others to correct the provisions on HTLV-III testing enacted in the biennial budget.

While the new law retains the requirement for a specific written consent form prior to performing an HTLV-III antibody test in most cases, it does resolve virtually all of the other problems identified with the current law.

For example, HTLV-III test information will continue to be included in a medical record; test results may be disclosed without the patient's consent to most (but not all) of the entities now given access without consent to medical records; and healthcare providers, including persons involved in patient care and in handling or processing specimens, may be informed of the test results without the patient's consent. Also, written consent is not required when an HTLV-III antibody test is performed for purposes of determining the medical suitability of an organ, blood, or other body part for donation.

The new law also provides for reporting of positive test results to the state epidemiologist. ■

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Lincoln CMS offers free colorectal cancer screening

LINCOLN: An initiative by the Lincoln County Medical Society to provide free colorectal cancer screening for one month has led to a resolution that will be brought before the SMS 1986 Annual Meeting.

M Y Ahmad, MD, president of the Lincoln medical group, has drafted the following proposal:

"Resolved, that colorectal cancer screening (Hemoccult® test) be offered for one month on a yearly basis by all State Medical Society members to improve colon cancer awareness and to find and treat new colorectal cancer patients."

A specific month has not yet been selected.

In a letter to SMS Secretary Earl R Thayer, Doctor Ahmad said, "President Reagan's recent cancer surgery has brought colon cancer to our nation's attention. The Lincoln County Medical Society physicians took this opportunity to improve colon cancer awareness in our communities. Free colorectal cancer screening was held for one month. As a result, new cases of colon cancer were found and treated. Because of the tremendous response, the Lincoln County Medical Society physicians have decided to offer colorectal cancer screening (Hemoccult® test) for one month on a yearly basis."

"The Lincoln County Medical Society is to be congratulated on its colorectal cancer screening project," Mr Thayer wrote Doctor Ahmad in advising him the resolution will be introduced to the House of Delegates.

MARINETTE-FLORENCE: Twenty-seven members and guests were present at the Marinette-Florence County Medical Society. Frederick Sobieray, DO, a member of the Boren Clinic in Marinette spoke on "Update Polypectomy Surveillance." New members accepted to membership are MDs Vernette M Carlson,* Sherwood A Cole,* Gerald W Favret,* Thomas J Knutson,* and Calvin D Nogler.*

OUTAGAMIE: At the October meeting of the Outagamie County Medical Society 21 members and guests were present. Guest speaker was Ellen Gruenbaum, PhD, professor of anthropology at the University of Wisconsin Center-Manitowoc. Her topic was "Who Are Healers?" Debra Bowen-Wilke, field representative of the SMS Physicians Alliance, answered questions regarding the meeting in Madison on the malpractice issue. An award was presented to Henry Chessin, MD,* for his past service as president of the County Society.

SHEBOYGAN: At the October meeting of the Sheboygan County Medical Society, MDs Robert W Pointer,* Jan P De Roos,* and Cynthia P Northrup* spoke on their recent medical mission experiences in Haiti, The Dominican Republic, and Central America. Sixty-nine members and guests were present at the combined meeting of the Medical Society and its Auxiliary.

WINNEBAGO: Ninety-four members and guests were present at the October meeting of the Winnebago County Medical Society. Guest speaker was Senator Susan Engeleiter, Menomonee Falls, who spoke on various legislative issues of current interest. A question and answer session followed the formal address of Senator Engeleiter.■

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SMS Services, Inc has negotiated an agreement with Modern Business Machines in Madison to provide SMS members with a discount on IBM Wheelwriter 3 Electronic and IBM Wheelwriter Selectronic typewriters (7K memory), with options. Also available is a discount on the Xerox Model 1020 and 1025 copiers with options.

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George Colville Owen, MD died in Milwaukee on July 25, 1985 at the age of 80. After receiving a BA degree from the University of Wisconsin in 1927 and attending the University of Wisconsin Medical School for two years, he graduated from Harvard Medical School in 1931 and served his internship at Boston City Hospital. From 1934 to 1942 he practiced internal medicine in Oshkosh, obtaining certification by the American Board of Internal Medicine and Fellowship in the American College of Physicians. He left Oshkosh to serve at Fitzsimmons Army Hospital and later served as Chief of Medicine at Bruns Army Hospital in Santa Fe during World War II. He returned to Milwaukee after six months with the Veterans Administration in Washington, DC, to practice internal medicine and chest diseases. He continued to serve the Veterans Administration as a consultant in tuberculosis at Wood Veterans Administration Medical Center. He also served on the Board of Directors of the Wisconsin Lung Association for 21 years. Jointly with Dr John Steele he served the State of Wisconsin, annually reviewing practice in state tuberculosis sanitoria that led to the establishment of the Pembine Chest Conference, which is ongoing. He served as Chief of Medicine at Columbia Hospital from 1966 through 1970. After retirement from office practice, he served full-time at Columbia Hospital as cost ombudsman, Director of the Library, liaison among the staff, board, and administration. Surviving are his wife, Mona V Owen of Milwaukee, and three sons: Nicholas L Owen, MD of Milwaukee; Tobias Owen of Long Island, New York; and George C Owen Jr, of Santa Fe, New Mexico.

Benjamin E Urdan, MD, 82, died Aug 15, 1985 in Milwaukee. Born Dec 15, 1902 in Milwaukee, Doctor Urdan graduated from Marquette University School of Medicine in 1927 and served his internship at Jewish Hospital in Cincinatti, Ohio. His residency was completed at Mt Sinai Hospital, New York, and Chicago Lying-In Hospital. He was one of the founders of the Milwaukee Obstetrics and Gynecology Society and also was an assistant clinical professor at Marquette University. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Marian; one son, Samuel (Karen) and two granddaughters.

Moktar Najafzadeh, MD, 79, former Twin Lakes physician, died Sept 4, 1985 in Miami, Florida. Born Apr 6, 1906 in Russia, Doctor Najafzadeh graduated from the Medical School of Lyon in France and served his internship at Val De Grace Hospital in Paris and his residency was completed in Istanbul, Turkey. Doctor Najafzadeh served for 23 years in the Iranian Army Medical Corps as general surgeon in Tehran and retired with the rank of Brigadier General in 1959. From 1960-1965 he completed a residency at the Coney Island Hospital, Brooklyn, New York. In 1966 Doctor Najafzadeh became the medical director of the McCoy Job Corps Center in Sparta. In 1970 he became associated with the Twin Lakes Medical Center and retired from medical practice in 1975. He was a member of the Kenosha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving is his widow, Karin, of Coconut Creek, Florida.

Gerald J Bergmann, MD, 71, Greenfield, died Sept 12, 1985 in Milwaukee. Born Dec 30, 1913 in Milwaukee, Doctor Bergmann graduated from Marquette University School of Medicine in 1939 and served his internship and residency at Milwaukee County General Hospital. He was chief of the Family Practice Center at St Luke's Hospital, Milwaukee, from 1961-1964. Doctor Bergmann was in private medical practice at the time of his death. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Ruth, and a daughter Christine Van Hefty of De Pere.

James D Zeratsky, MD, 71, Marinette, died Sept 29, 1985 in Marinette. Born Oct 5, 1914 in Marinette, Doctor Zeratsky graduated from Northwestern University School of Medicine and served his internship at University Hospitals in Madison. Doctor Zeratsky was associated with the Boren Clinic. He was a member of the Marinette-Florence County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Ruth; one daughter, Merry Jane Lindt, Marinette; four sons, John, Jeff, Joseph, and Jeremy, all of Marinette.

Anthony S Kult, MD, 80, Milwaukee, died Oct 7, 1985 in Milwaukee. Born Nov 24, 1904 in Budapest, Hungary, Doctor Kult graduated from Marquette University School of Medicine and served his internship at St Joseph Hospital, Milwaukee. He was a member of the "Fifty Year Club" of the State Medical Society of Wisconsin, a member of The Medical Society of Milwaukee County, and the American Medical Association. Surviving is a son, Dale.■

BLUE BOOK UPDATE

On page 131 of the June BLUE BOOK under the heading Officers of Specialty Sections the following changes have been made:

ANESTHESIOLOGISTS
Chairman . . . . . Young K Lee, MD
1836 South Ave, La Crosse 54601

INTERNAL MEDICINE
Chairman . . . . . James R Mattson, MD
501 S Military Ave, Green Bay 54303
Secretary-Treasurer . . . . . Cyril M Hetsko, MD
1313 Fish Hatchery Rd, Madison 53715
Delegate . . . . . James R Mattson, MD
501 S Military Ave, Green Bay 54303
Alternate Delegate . . . . . Charles S Geiger Jr, MD
279 S 17th Ave, West Bend 53095

RADIOLOGY
Alternate Delegate . . . . . Bruce C Kirkham, MD
3737 Claymore Lane, Eau Claire 54701

On page 133 under the heading of Officers of Specialty Societies the following changes have been made:

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS
President . . . . . Young K Lee, MD (Sept 1986)
1836 South Ave, La Crosse 54601

WISCONSIN SOCIETY OF INTERNAL MEDICINE
President . . . . . James R Mattson, MD (Sept 1986)
501 S Military Ave, Green Bay 54303
Secretary . . . . . Cyril M Hetsko, MD (Sept 1986)
1313 Fish Hatchery Rd, Madison 53715

WISCONSIN RADIOLOGICAL SOCIETY
President . . . . . Mary Ellen Peters, MD (Oct 1986)
600 Highland Ave, Madison 53792■

NEWS HIGHLIGHTS

*Physician members of the State Medical Society of Wisconsin

Columbus Community Hospital recently selected Mr Miles Meyer as the new administrator for the hospital. Mr Meyer received a Master's degree in Hospital and Health Administration from the University of Iowa College of Business. Prior to joining the Columbus Community Hospital staff, Mr Meyer was the administrator of Ipswich Community Hospital in South Dakota.

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

Marshfield Clinic Executive Director Frederick J Wenzel has received the Group Practice Administrator recognition award from the American Group Practice Association. The award, which was given for the first time, is "reserved for outstanding group practice administrators . . . respected leaders who contribute not only to the administrative success of their own medical groups but also to their profession through creative, informative, and relevant group practice administration." Mr. Wenzel began his career at the medical center in 1950 as a research assistant at St Joseph's Hospital. In 1953 he became director of laboratories at the Clinic, and in 1965, executive director of the Marshfield Medical Foundation. He has been executive director of the Clinic since 1977. He was presented the award by David Ottensmeyer, MD, former president of Marshfield Clinic and currently head of Lovelace Medical Foundation, Albuquerque, New Mexico.

St Mary's Medical Center medical staff, Racine, recently elected officers. Joseph D Postorino, MD* was elected to the second half of a two-year term as chief-of-staff. Henry E DeGroot, MD* was reelected secretary and Edward A Stika, MD* serves as the immediate past chief-of-staff. Department chiefs elected include MDs Robert D Shaffer,* medical department; Hark C Chang,* surgical department; Louis J Floch,* gynecology department; Peter DeGroot, pediatric department; Gerald J Sampica,* family practice department; and William C Harris,* was reappointed as chief of the emergency committee. Other executive committee appointments were MDs Donald F Cohill,* chairman, Utilization Review Committee, and Huron L Ericson,* chairman, Medical Audit Committee.■

Jay F Schamberg, MD,* West Allis, recently was given an award for "Distinguished Service to Public Health." The award was presented to Doctor Schamberg at the Wisconsin Public Health Association Annual Conference. Doctor Schamberg is on the medical staff at West Allis Memorial and Menomonee Falls hospitals, and has provided countless hours of volunteer service to the Waukesha County Health Department. This award is given for significant contribution to public health in the community or the state and the recipient is to be a Wisconsin resident not employed in a public health agency. Doctor Schamberg is a pathologist.

Cynthia Jones-Nosacek, MD, recently joined the medical staff at the Falls Medical Group in Menomonee Falls. Doctor Jones-Nosacek graduated from the Loyola University Stritch School of Medicine and completed her residency in family practice at Resurrection Hospital in Chicago.

Michael V Darnieder, MD,* has joined the medical staff at the Falls Medical Group in Menomonee Falls. Doctor Darnieder graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency in ophthalmology at Henry Ford Hospital in Detroit. He was chief of residents at Henry Ford Hospital in 1984 and 1985.

Eugene J Nordby, MD,* Madison, recently was reelected president of the Board of Trustees of Vesterheim, the Norwegian-American Museum, at the annual meeting of Vesterheim Trustees held in Baltimore. Vesterheim, located in Decorah, Iowa, is considered the oldest and most comprehensive immigrant ethnic museum in the nation; it has been collecting objects relating to Norwegian immigrant history since 1877.

Timothy J Zelko, DO,* a graduate of the Philadelphia College of Osteopathic Medicine, recently joined the medical staff at the Falls Medical Group in Menomonee Falls. Doctor Zelko completed his residency at St Joseph's Hospital in Milwaukee.

Matthew W Elson, MD,* Brookfield, recently was named a fellow of the American College of Radiology. Doctor Elson is associated with the West Allis Memorial Hospital and is a graduate of the Ohio State University College of Medicine in Columbus, Ohio.

Cesar N Reyes Jr, MD,* Marshfield Clinic vice president, recently was elected to a three-year term on the Board of Trustees of the American Group Practice Association. He will represent the central region of the United States on the 13-member board. Doctor Reyes joined the Clinic in 1966 and is presently serving as Director of Laboratories. He has been a member of the Clinic's Executive Committee for 12 of the past 13 years.

John M Coffey, MD,* Milwaukee, has been named medical director of the De Paul Rehabilitation Hospital Impaired Professional Program. He replaced MDs August D Kropp* and Mark D Biehl* who had been co-medical directors since October 1984. Doctor Coffey has been serving in the De Paul Barrows' Fellowship.

Michael M Miller, MD,* Eau Claire, recently was appointed to the managing committee of the State Medical Society Statewide Impaired Physician Program. Comprised of six to nine members of the medical profession from throughout the state, the committee was organized to develop a plan for implementing an effective program to aid physicians impaired by alcohol or drug abuse, psychiatric disorders or physician disability. Doctor Miller is on the medical staff of the Midelfort Clinic in Eau Claire.

Wayne Peterson, MD, Burlington, has joined the medical staff of Medical Consultants in Burlington. Doctor Peterson graduated from Rush Medical College and completed his residency program at Rush-Christ Family Practice in Chicago.

Gerald W Favret, MD,* Marinette, recently became associated with the Boren Clinic. Doctor Favret graduated from the Medical College of Ohio and completed his residency at Grant Medical Center in Toledo. He is a diplomate of the American Academy of Family Practice.

Susan R Bernstein, MD,* Shorewood, has opened a medical practice in association with Larry J Polacheck, MD.* She graduated from Northwestern University Medical School and served her residency training at the University of Chicago Hospitals and Clinics and Wyler Children's Hospital. She currently is a clinical assistant professor at the Medical College of Wisconsin in Milwaukee.

Timothy J Freeman, MD,* Green Bay, has joined the medical staff of the West Side Clinic. He graduated from the University of Wisconsin Medical School, Madison, and served his internship at Mount Sinai Medical Center in Milwaukee.

David Myerowitz, MD, Madison, head of the heart transplant team at the University of Wisconsin Hospital and Clinics, is leaving the university to direct a new transplant program at Ohio State University. Doctor Myerowitz has been a UW surgeon for six and one-half years and chief heart transplant surgeon since the program was revived in 1984. Doctor Myerowitz will be chief of cardiac surgery at Ohio State University effective December 1.

Viktor Gottlieb, MD, Marshfield, recently became associated with the Marshfield Clinic. He is a graduate from the University of Illinois Medical Center, Chicago, and served his internship and residency at the University of Iowa Medical Center in Iowa City. He practiced at General Leonard Wood Army Hospital at Fort Leonard Wood, Mo, and then completed a plastic surgery residency at Fitzsimons Army Medical Center in Aurora, Colo.

Leonas P Sulas, MD,* Portage, recently opened his medical practice in Portage. He graduated from the University of Vienna in Austria and served a residency at Mercy Hospital in Pittsburgh and at the University of Illinois Hospital in Chicago.

Gregory C Doelle, MD, Marshfield, has joined the medical staff of the Marshfield Clinic in the Department of Internal Medicine, Section of Endocrinology. Doctor Doelle graduated from the University of Minnesota Medical School where he also completed his residency. His fellowship in endocrinology was served at Vanderbilt University, Nashville, Tenn. Prior to joining the Clinic, he was director of internal medicine at Broadlawns Polk County Medical Center in Des Moines, Iowa.

Richard W Shropshire, MD,* Monona, was reelected speaker of the Congress of Delegates of the American Academy of Family Physicians. Doctor Shropshire has been in medical practice at the Monona Grove Clinic since 1957. He also is an associate clinical professor of family medicine and practice at the University of Wisconsin Medical School in Madison. He was elected to his first term as AAFP speaker in 1984 and prior to that, he served two terms as vice speaker.

Michael C Stark, DO,* Tomah, recently became associated with MDs James R Deming,* Michael J Saunders,* and Gustave A Landmann* at the Lake Tomah Clinic. Doctor Stark graduated from the College of Osteopathic Medicine and Surgery in Des Moines, Iowa, and served an internship at Northwest General Hospital in Milwaukee. His family practice residency was completed in the St Mary's Hospital residency program in Milwaukee. Prior to joining the Lake Tomah Clinic, Doctor Stark was in private medical practice in Cedar Rapids, Iowa.

Gloria M Halverson, MD,* Brookfield, has won the "Women of Distinction" award from the Christoph Memorial YWCA. Doctor Halverson is affiliated with Women Care of Waukesha, Milwaukee County Medical Complex, Waukesha Memorial Hospital, and Elmbrook Hospital. She is a member of the American College of Obstetrics/Gynecology Task Force on the Advancement of Women in Obstetrics and Gynecology. She also is a member of the SMS Committee on Maternal and Child Health.

William C Crawford III, MD, Sheboygan, has joined the medical staff of the Sheboygan Clinic. Doctor Crawford has practiced in Sheboygan since 1979. He graduated from the University of Maryland School of Medicine, Baltimore, and completed his residency at the University of Florida. He is a member of the medical staffs at St Nicholas and Sheboygan Memorial hospitals.■

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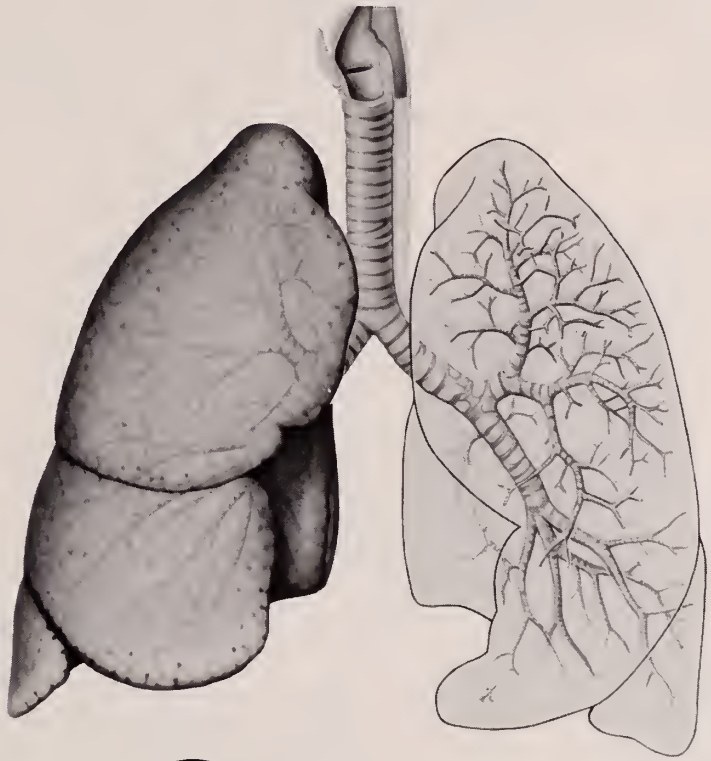

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offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

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Please see brief summary on following page.

ISOPTIN®
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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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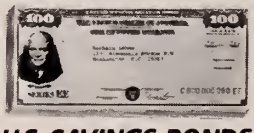

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INDEX

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KEY TO NUMBERING: First number is the issue number (*eg,* January is 1, February is 2, etc) followed by a hyphen and the page number within the issue.

AUTHORS* OF SCIENTIFIC ARTICLES

Agger, William A, La Crosse: 2-27, 9-18
Abram, Stephen E, Milwaukee: 5-7
Annis, Byron L, La Crosse: 11-15
Avecilla, Constance S, Marshfield: 8-21

Bamrah, Virinderjit, Wood: 3-25

Campbell, Bruce H, Milwaukee: 10-22
Caplan, Robert H, La Crosse: 5-12
Chatton, Thomas B, Milwaukee: 10-22
Chusid, Michael J, Milwaukee: 2-21, 10-22
Clayton, Ellen Wright (JD), Madison: 3-28
Cogbill, Thomas H, La Crosse: 11-15
Craviotto, Don (BS), Milwaukee: 8-11

Dahlberg, Philip J, La Crosse: 5-16, 11-15
Davis, Jeffrey P, Madison: 2-27
Deering, William M, La Crosse: 11-15
De Kraay, Warren H, Kenosha: 2-32
Drinka, Paul, Madison: 4-16
Duthie, Edmund, Wood: 3-25

Falk, Victor S, Edgerton: 5-14
Feins, Robert S, Madison: 10-15
Franson, Timothy R, Milwaukee: 4-19
Funahashi, Akira, Milwaukee: 11-11
Furlano, Frank, La Crosse: 9-18

Garland, Jeffrey S, Milwaukee: 2-21
Gerwood, Joseph B (RN, BS), Washburn: 1-19
Grunert, Brad K (PhD), Milwaukee: 5-7
Gunnarson, Cindy (non-MD), Waukesha: 11-9
Guten, Gary N, Milwaukee: 8-11
Gutmann, Frank D, Milwaukee: 2-31
Gutschenritter, Peter W, La Crosse: 5-16

Halverson, Gloria M, Waukesha: 11-9
Hubert, Bruce C, Marshfield: 8-21

Jefferson, James W, Madison: 2-23
Johnson, Kevin T, Milwaukee: 11-11

Karofsky, Peter S, Madison: 12-19
Katayama, K Paul, Waukesha: 11-9
Kim, Byung (Robert) H, Racine: 9-15
Kirchner, John P, Marshfield: 5-10
Kolts, R Lee, Marshfield: 9-21
Kurtz, Jeff, Wausau: 4-13

Larratt, Kari S (MS), Milwaukee: 4-19
Larson, Jeffrey, Milwaukee: 3-33
Lynch, Timothy, Milwaukee: 5-7

Maloney, Patrick M, Marshfield: 5-10
Maly, Betty Joan, Milwaukee: 3-33
Maurer, William J, Marshfield: 8-13
Melvin, John L, Milwaukee: 5-7
Meyer, Matthew A, Waukesha: 11-9
Mirick, Mark J, Wausau: 4-13
Myers, Bruce (non-MD), Milwaukee: 10-24

Nazer, LeeAnne, Milwaukee: 8-16
Newcomer, Kermit L, La Crosse: 5-16

Parker, Eugenia H, Washburn: 1-19
Pitot, Henry C, Madison: 12-25
Pohlmann, Guenther P, Milwaukee: 2-25
Ptacin, Michael J, Wood: 3-25

Rao, Venkat K, Madison: 10-15
Redmann, Beverly (BS), Madison: 2-23
Reynolds, Norman C Jr, Milwaukee: 10-20
Roesler, Mark (non-MD), Waukesha: 11-9
Rytel, Michael W, Milwaukee: 4-19, 8-16

Sheehy, Greg, Madison: 4-16
Short, Howard H, Racine: 9-15
Songsiridej, Vanee, La Crosse: 2-27
Spiro, Joanna (EdD), Milwaukee: 3-33
Sullivan, Bradley, Marshfield: 3-23
Sutton, Thomas M, Marshfield: 3-23

Tanner, George, Wausau: 4-13
Turner, Paul A, Milwaukee: 4-19

**All authors are MDs unless otherwise indicated*

AUTHORS OF SCIENTIFIC ARTICLES *continued*

Vasudevan, Sridhar V, Milwaukee: 5-7, 10-24

White, Lynn Rosen, Madison: 12-19
Wickus, Gary G (PhD), La Crosse: 5-12
Wirtz, Charles E, Marshfield: 5-10

Yale, Russell S, Milwaukee: 10-22

Zilz, Mary Ann (RN), Madison: 2-33

AUTHORS* OF NONSCIENTIFIC ARTICLES

Davis, Frederick J, Madison: 12-13
Flemma, Robert J, Milwaukee: 6-33
Glicklich, Lucille B, Milwaukee: 5-23
Handy, George H, Madison: 2-16
Locher, Roland A, La Crosse: 3-16
Peters, David A (PhD), Stevens Point: 12-10
Schmidt, Susan M (JD), Chicago, IL: 6-41

All authors are MDs unless otherwise indicated

SCIENTIFIC ARTICLES / ABSTRACTS / INFORMATION

Acquired Immunodeficiency Syndrome or prodromal syndromes, clinical and laboratory findings in ten Milwaukee patients with the (Turner, Larratt, Franson, Rytel): 4-19
Adenocarcinoma of the gallbladder and cystic duct, *Clonorchis sinensis* infection associated with (Drinka, Sheehy): 4-16
Aging, Linguistics offers study tool for: 1-33
AIDS—Acquired Immune Deficiency Syndrome: 6-59
—testing, Statewide network set up for: 8-27
Amyloid cardiomyopathy, Technetium^{99m} pyrophosphate scintigraphy in (Ptacin, Bamrah, Duthie): 3-25
Aneurysm of the ascending thoracic aorta causing obstruction and embolism of right pulmonary artery (Kim, Short): 9-15
Anorectal Giant condyloma acuminatum (Kolts, Hubert, Avecilla): 9-21
Antiparkinsonian agents?, Old versus new (Reynolds): 10-20
Asbestos Body; Malignant mesothelioma (De Kraay): 2-32

Blood and blood products: Case report of post-transfusion Hepatitis-B, Hazards of (Wirtz, Kirchner, Maloney): 5-10
Blood Cholesterol to prevent heart disease, Lowering: 10-18
Blood Pressure Advisory Committee, Is high too low? A commentary by the Wisconsin State High (Gutmann): 3-31
—Elevated blood pressure (Falk)(editorial): 1-7
Bone scan changes in a marathon runner; case report (Guten, Craviotto): 8-11
Brain Injury, Malignant posttraumatic hypermetabolic syndrome associated with (Dahlberg, Cogbill, et al): 11-15
Bronchogenic Carcinoma . . . Successful management with staged bilateral thoracotomy, Severe bullous emphysema and contralateral (Johnson, Funahashi): 11-11

Cancer: See Clinical cancer
Cadaver organs for transplantation; Required request: A practical proposal for increasing the supply of (Peters): 12-10
Carcinoma of the lower lip, Microscopically controlled surgical treatment for squamous cell (abstract): 9-24
—of the penis, Microscopically controlled surgery in the treatment of (abstract): 10-28
Cardiomyopathy, Technetium^{99m} pyrophosphate scintigraphy in amyloid (Ptacin, Bamrah, Duthie): 3-28
Carotid Artery procedures, Patient selection and results of simultaneous coronary and (abstract): 4-15
Chelation therapy: 1-68
Clinical cancer; New discoveries in oncology: Potential applications to clinical practice (No. 1 of a series)(Pitot): 12-25
Clonorchis Sinensis infection associated with adenocarcinoma of the gallbladder and cystic duct (Drinka, Sheehy): 4-16
Condyloma acuminatum, Anorectal giant (Kolts, Hubert, Avecilla): 9-21
Corticosteroids; Reflex sympathetic dystrophy syndrome: Importance of early diagnosis and appropriate management (Vasudevan, Myers): 10-24
Critical Care: Ethical decision-making in the care of seriously ill patients (Pohlmann): 2-25
Cyclosporine controls herpes eye infection: 1-14

DES-exposure information, Suggested patient form for obtaining: 3-17
—exposed women, Tissue abnormalities twice as likely for: 1-30
—Forty years of fallout (editorial): 2-8
Diethylstilbestrol (DES) update[1], A message from the DESAD Project: 2-11
—Forty years of fallout (editorial): 2-8
Disability Programs, Documentation needs of the Social Security Administration (Handy): 1-16
DPT shortage, Interim recommendation issued on: 1-68
Dystrophy syndrome: Importance of early diagnosis and appropriate management, Reflex sympathetic (Vasudevan, Meyers): 10-24

Embryo transfer, In vitro fertilization and (Katayama, et al): 11-9
Emphysema and contralateral bronchogenic carcinoma . . . Successful management with staged bilateral thoracotomy, Severe bullous (Johnson, Funahashi): 11-11
Epidemiology; *Neisseria meningitidis* serogroup Z as a cause of meningitis (Nazer, Rytel): 8-16
Epstein-Barr virus; Review of the clinical manifestations, laboratory findings, and complications of infectious mononucleosis (White, Karofsky): 12-19
Ethical Decision-Making in the care of seriously ill patients (Pohlman): 2-25

Farm accidents in children (abstract): 11-14
(Fitz-Hugh—Curtis Syndrome), Perihepatitis (abstract): 4-15

Gallbladder and cystic duct, *Clonorchis sinensis* infection associated with adenocarcinoma of (Drinka, Sheehy): 4-16
Genetics in Wisconsin, Legal aspects of (Clayton): 3-28
Genital herpes a trivial disorder, Recurrent: 5-17
Graft patency, Postoperative surveillance: An effective means of detecting correctable lesions that threaten (abstract): 5-11

Heart disease, Lowering blood cholesterol to prevent: 10-18
Henoch-Schoenlein purpura: Association with unusual vesicular lesions (Garland, Chusid): 1-21
Hepatitis-B, Hazards of blood and blood products: Case report of post-transfusion (Wirtz, Kirchner, Maloney): 5-10

SCIENTIFIC ARTICLES / ABSTRACTS / INFORMATION *continued*

Herpes a trivial disorder, Recurrent genital: 5-17
—eye infection, Cyclosporine controls: 1-14
Hyphema, The incidence of rebleeding in traumatic (abstract): 11-14
Hypothyroid man with severe nonthyroidal illnesses, Absent serum thyroxine in a (Wickus, Caplan): 5-12

Infectious mononucleosis; Review of the clinical manifestations, laboratory findings, and complications of (White, Karofsky): 12-19
In vitro fertilization and embryo transfer (Katayama, et al): 11-9
Irradiated foods (Falk)(editorial): 10-6

Kawasaki disease in rural Wisconsin, Endemic (Sutton, Sullivan): 3-23
Kerototomy problem, Poor predictability major radial: 1-14

Leptospirosis in Wisconsin: Report of a case associated with direct contact with raccoon urine (Falk): 5-14
Lesions, Henoch-Schoenlein purpura: Association with unusual vesicular (Garland, Chusid): 1-21
—that threaten graft patency, Postoperative surveillance: An effective means of detecting correctable (abstract): 5-11
Listeriosis in Bayfield County, A case (Parker, Gerwood): 1-19
Lithium and Wisconsin—A medicinal trip through history (Redmann, Jefferson): 2-23
Long-term care facilities in Wisconsin, A survey showing current status of medical directors and (Zilz): 2-34

Magnetic resonance imaging (MRI): View of the Wisconsin Radiological Society (Locher): 3-16
—MRI (Falk)(editorial): 4-6
Malignant posttraumatic hypermetabolic syndrome associated with brain injury (Dahlberg, et al): 11-15
Mannitol-induced renal insufficiency (Gutschenritter, Newcomer, Dahlberg): 5-16
Medical ethics; Ethical decision-making in the care of seriously ill patients (Pohlmann): 2-25
Meningitis, *Neisseria meningitidis* serogroup Z as a cause of (Nazer, Rytel): 8-16
Mesothelioma, Malignant (De Kraay): 2-32
Metastases, Multiple biopsies linked to: 5-17
Microsurgery; Replantation for ring avulsion injuries (Rao, Feins): 10-15
Milwaukee shoulder (Falk)(editorial): 8-7
Mononucleosis; Review of the clinical manifestations, laboratory findings, and complications of infectious (White, Karofsky): 12-19
(MRI): View of the Wisconsin Radiological Society, Magnetic resonance imaging (Locher): 3-16
—editorial: 4-6

Neisseria Meningitidis serogroup Z as a cause of meningitis (Nazer, Rytel): 8-16
Nifedipine offers rapid hypertension treatment: 1-26

Oncology; New discoveries in (Clinical cancer series, No. 1)(Pitot): 12-25
Otomastoiditis, Tuberculous (Campbell, Chatton, Chusid, Yale): 10-22

Pain: long-term results, Outpatient management of chronic (Vasudevan, et al): 5-7
Parkinsonism; Old versus new antiparkinsonian agents? (Reynolds): 10-20
Penis, Microscopically controlled surgery in the treatment of carcinoma of (abstract): 10-28
Perihepatitis (Fitz-Hugh—Curtis syndrome) (abstract): 4-15
Periorbital melanoma: Fixed-tissue and fresh-tissue techniques, Microscopically controlled surgery for (abstract): 10-19
Physician morbidity: a limited study (Larson, Maly, Spiro): 3-33
Plasma, Fresh frozen (Falk)(editorial): 3-9
Pleural plaques; Malignant mesothelioma (De Kraay): 2-32
Pneumatic injury from a nailgun (Mirick, Kurtz, Tanner): 4-13
Pneumoconosis radiologic consultation program begins June 1, Statewide: 5-38
Poison-warning stickers may not work: 1-14
Prodromal Syndromes, Clinical and laboratory findings in ten Milwaukee patients with the acquired immunodeficiency syndrome or (Turner, Larratt, Franson, Rytel): 4-19
Pulmonary artery, Acute dissecting aneurysm of the ascending thoracic aorta causing obstruction and embolism of right (Kim, Short): 9-15

Radiation accident victims concerns SMS EOH Committee, Hospital preparedness in treating: 1-48
Renal insufficiency, Mannitol-induced (Gutschenritter, Newcomer, Dahlberg): 5-16
Replantation for ring avulsion injuries (Rao, Feins): 10-15
Ring avulsion injuries, Replantation for (Rao, Feins): 10-15
Rocky Mountain Fever, Abdominal symptoms one sign of: 1-20

Silo-filler's disease: A historical perspective and report of a case (Maurer): 8-13
Splenic autotransplantation, Splenic phagocytic function after partial splenectomy and (abstract): 8-13
Sympathetic dystrophy syndrome: Importance of early diagnosis and appropriate management (Vasudevan, Myers): 10-24

Technetium^{99m} pyrophosphate scintigraphy in amyloid cardiomyopathy (Ptacin, Bamrah, Duthie): 3-25
Thiabendazole; Visceral larva migrans (Furlano, Agger): 9-18
Thoracic aorta causing obstruction and embolism of right pulmonary artery, Acute dissecting aneurysm of the ascending (Kim, Short): 9-15
Thyroxine in a hypothyroid man with severe nonthyroidal illnesses, Absent serum (Wickus, Caplan): 5-12
Tourette syndrome (Ward)(letter): 6-15
Toxic organic gas; Silo-filler's disease (Maurer): 8-13
Transplantation; Required request: A practical proposal for increasing the supply of cadaver organs for (Peters): 12-10
Tuberculosis treatment, Consensus on: 5-9
Tuberculous otomastoiditis (Campbell, Chatton, Chusid, Yale): 10-22
Typhus acquired in Wisconsin, Epidemic (Agger, Songsiridej): 2-27
—Commentary: Epidemic typhus in Wisconsin (Davis): 2-29

Vegetative Syndromes; Malignant posttraumatic hypermetabolic syndrome associated with brain injury (Dahlberg, et al): 11-15
Visceral larva migrans (Furlano, Agger): 9-18

Weil's syndrome: Leptospirosis in Wisconsin: Report of a case associated with direct contact with raccoon urine (Falk): 5-14

MEDICOLEGAL / SOCIOECONOMIC / ANCILLARY

Abortion: 6-73
Abuse and neglect; Child: 1-11
—Also see Child Abuse
—education in school; Pediatricians establish policy for alcohol: 3-18
—Elderly: 6-76
Administrative code, Wisconsin: 6-82
Adoption agencies, Wisconsin: 6-53
—process in Wisconsin: 6-73
—records law: 6-73
Aging, SMS leaders discuss health issues of the elderly with Coalition of: 1-49
—Linguistics offers study tool for aging: 1-33
—The patient is our first consideration (Flaherty)(President's Page): 1-4
AIDS testing, Statewide network set up for: 8-27
Alcohol abuse education in school; Pediatricians establish policy statement for: 3-18
—abuse; Medical Society asks broadcasters to help fight: 3-40
AMA helping states track physician licensing actions: 4-79
—Guide for Hospital Medical Staff Bylaws available: 4-79
—book wins award: 1-33
—Department of Practice Management 1986 workshops: 11-28
Attorney fees; Legislative committee backs cap on: 1-50
Autopsy: 6-73
—Sudden infant death (SID) syndrome: 6-73

Baby Doe rules proposed; New: 2-68
Biomedical ethics conference coming up June 6 and 7: 4-80
Board certification increasing rapidly: 7-128
Budget bill; Governor's: 4-80
—Governor vetoes chiropractic coverage in: 7-128

Care and treatment facilities; Division of: 6-146
Casualty medical report form; Standard: 6-79
Certificate-of-need regs; Health Policy Council to look at: 1-51
Certification: 6-73
—increasing rapidly; Board: 7-128
Chelation therapy: 1-68
Child abuse and neglect: 1-11
—Be aware (Foster)(letter): 1-7
—Abused child law: 6-73
—Physicians must report, and neglect: 1-68
—After the report is made: 3-13
—and neglect: The law—explanation and implication (1983 Wisconsin Act 172): 2-15
—Save a child—save the world (editorial): 4-2
—Physicians more aware of child sexual abuse: 5-58
Child safety restraint systems: 6-74
Chiropractic coverage in Budget bill; Governor vetoes: 7-128
—veto action commended; Governor's (Scott, Thayer)(letter): 9-12
—Skulduggery in the Senate (Falk)(editorial): 8-6
Chiropractors to draw blood; SMS seeking repeal of rule allowing: 2-68
Claims rejected; Bill waiving interest on overdue insurance: 10-47
Clearinghouse, Wisconsin: 6-97
Closing of a physician's practice; Some considerations in the: 6-93
Commitment laws; SMS speaks out on mandated benefits, involuntary: 4-48
—Too late (Falk)(editorial): 5-5
—SMS physicians testify for additional mental, standard: 10-47
Communicable disease laws; Recently enacted: 6-58
—Communicable diseases: 6-74
Community services, Division of: 6-144
—Regional offices: 6-145
—District offices: 6-145
—Controlled Substances Board: 6-144
CON regs; Health Policy Council to look at: 1-51
—Welcome to Wisconsin Regulation (Flaherty)(President's Page): 3-5
Consent and related forms for physicians; Use of: 6-83
—Consent forms for physicians: 6-83
Contact lenses; Long-wear (Falk)(editorial): 12-6
Controlled Substances Board: 6-144
Costs; Uncompensated care problem looms on horizon, SMS President says: 2-50
—Reform malpractice system to cut, Medical Society tells Legislature: 2-50
—Brown CMS plan wins acclaim: 9-39
—1983 Health spending: 3-49
—Governor delivers 1985-87 budget; many healthcare items included: 3-49
—Maximum care at minimum cost (Scott)(President's Page): 8-5
Countersuits: 6-25

Death; Determination of: 6-74
"Denial of access" to healthcare records: 6-74
DES-exposure information; Suggested patient form for obtaining: 3-17
Disability claims: 6-74
—Insurance Program in Wisconsin; Social Security: 1-6
DPT shortage; Interim recommendations issued on: 1-68
Drivers' licenses for epileptics: 6-75
DRGs?; Have you been receiving complaints from patients about: 4-79
Drug substitution law: 6-75
Drunk drivers in other countries; How they handle: 1-49

Elderly abuse: 6-76
—SMS leaders discuss health issues of the elderly with Coalition of Aging: 1-49
Epileptics; Drivers' licenses for: 6-75
Ethical and judicial Affairs, Council on: 12-72
Ethics conference coming up June 6 and 7; Biomedical: 4-80
Expense reimbursement policy and procedure for physicians on State Medical Society business: 6-109

Fee assessments due; Fund: 8-24
—discrimination (Schwarz)(letter): 6-15
—freeze; Medicare: 9-39
—freeze; Effects of an extended: 11-56
—increases slow; Physician: 3-64
—splitting statute; Wisconsin's: 6-54
—Legislative committee backs cap on attorney fees: 1-50

Guides help you; Let these: 1-67, 6-80

Health and Social Services; Department of: 6-143
Health, Division of: 6-143
—Center for Health Statistics: 6-144
—Map of Regions: 6-144
—problems available; Report on school: 1-49
—related information in Wisconsin; How to get: 6-44
—trends as reported by the National Health Lawyers Association: 5-57
Health Policy Council to look at CON regs: 1-51
Health prospects 1983/2003 survey reported: 12-72
Health Systems Agencies, Wisconsin: 6-148
—Physician members of Health Systems Agency Boards: 6-148
Healthcare records; "Denial of Access" to: 6-74
—costs: See under Costs
—items included; Governor delivers 1985-87 budget; many: 3-49

MEDICOLEGAL / SOCIOECONOMIC / ANCILLARY *continued*

HMO update: 8-50
—Governor delivers 1985-87 budget; many healthcare items included: 3-49
—The urge to merge (Scott)(President's Page): 7-4
—It's confusing (Falk)(editorial): 7-5
—Madison medicine (Manhart)(editorial): 7-5
—Let's control our own destiny (Maurer)(letters): 12-8
Hospital emergency rooms and outpatient facilities are aware of the following federal and state laws which prohibit . . . Wisconsin: 6-72
—staff privileges; Hospitals required to report physician's loss of: 6-72

Impaired Physician Program; Statewide: 6-45
—Legal aspects of peer review (Schmidt): 6-41
—Peer review in Wisconsin: 6-43
Industry, Labor and Human Relations, Department of: 6-146
Injuries; Work-related (letter)(Hargarten): 3-10
Insurance claims rejected; Bill waiving interest on overdue: 10-47
—rates higher for some Michigan physicians: 11-56

JCAH publishes the Hospice Project Report: 9-54
—announces new *Quality Review Bulletin: 12-72*

Laws; Good samaritan law: 6-76
—Implied consent law: 6-76
—Optometrist referral law: 6-76
—Charter Law of Medical Societies (Chapter 148): 6-102
—Abused child law: 6-73
—Child abuse and neglect: The law—explanation and implication (1983 Wisconsin Act 172): 2-15
—Drug substitution: 6-75
—Fee splitting statute; Wisconsin's: 6-54
—SMS speaks out on mandated benefits, involuntary commitment: 4-48
Legal aspects of medical genetics in Wisconsin (Clayton): 3-28
Legislation; SMS testifies on pituitary gland removal: 9-54
Legislative committee backs cap on attorney fees: 1-50
—leadership announced: 2-52
—Status Report: 12-43
Legislators together; Reception brings 800 physicians and 100: 11-21
Legislature; A brief profile of the 1985 Wisconsin State: 4-50
—Reform malpractice system to cut costs, Medical Society tells: 2-50
Letters: 1-7, 3-10, 4-9, 6-14, 9-12, 10-10, 12-7
—Be aware (Foster): 1-7
—Medical staffs and peer review (Sivertson): 3-10
—Work-related injuries (Hargarten): 3-10
—William H Studley, MD: 1903-1985 (Moore): 3-11
—Nicaragua—diversified views (Madiedo; Keane, et al; Dibbell; Peters): 4-9
—Is your hospital in compliance? (Lindesmith): 4-11
—The public, malpractice, the Wisconsin Patients Compensation Fund, and us (Boulanger): 6-14
—Fee discrimination (Schwarz): 6-15
—Tourette syndrome (Ward): 6-15
—The urge to reverse (Rengel): 9-12
—Governor's chiropractic veto action commended (Scott, Thayer): 9-12
—An overview of the Medical Examining Board (Nichols): 10-10
—New drugless healers? (La Joie): 12-7
—Med student offers perspective on physical therapy (Muir): 12-8
—Milwaukee brace (Gaenslen): 12-8
—Let's control our own destiny (Maurer): 12-8
Liability: See Malpractice

Licensure verification procedure; Physician: 6-81
—Physician re-registration: 6-81
Lilly ad discontinued; Farewell (Falk)(editorial): 1-7
Litigation: 8-23

Malpractice; SB 328 and medical (Scott)(President's Page): 11-5
—focus of Milwaukee county society meeting: 1-52
—seizures (Flaherty)(President's Page): 2-5
—panels: Are they the solution? (Boulanger)(editorial): 2-6
—panels: The Society's view (Johnson)(editorial): 2-6
—What's your opinion?: 2-7
—committee backs SMS peer review proposal: 2-51
—system to cut costs, Medical Society tells Legislature; Reform: 2-50
—premiums to rise 106%: 4-49
—problem; SMS asks business leaders' help on: 4-49
—seminar scheduled for May 11: 4-49
—Some thoughts about "The Fund": 5-5
—Ten statewide press conferences in two days: 11-42
—SMS Liability Task Force chairman testifies: 11-42
—conference tapes; Medical: 11-43
—A dilemma in the search for justice; Medical (Flemma): 6-33
—The public, malpractice, the Wisconsin Patients Compensation Fund, and us (Sautter)(letter): 6-14
—law is 'significant'; AMA says Supreme Court action on California: 12-72
Magnetic resonance imaging; MRI (Falk)(editorial): 4-6
Medicaid medical audit: 8-23
Medical ethics: 6-111
—American Medical Association—Principles of: 6-108
—Current opinions of the Judicial Council of the American Medical Association: 6-111
Medical Examining Board; An overview of the (Nichols)(letter): 10-10
—The public, malpractice, the Wisconsin Patients Compensation Fund, and us (Sautter)(letter): 6-14
Medical genetics in Wisconsin; Legal aspects of (Clayton): 3-28
Medical liability—a physician's rights and responsibilities: 6-31
—8-23
—Reception brings 800 physicians and 100 legislators together: 11-21
—Telling testimony (editorial): 12-6
Medical malpractice: See also Malpractice
Medical marketing; Three thousand surgeries (Falk)(editorial): 1-7
—fee freeze: 9-39
Medical report form; Standard casualty: 6-79
Medical staffs and peer review (Sivertson)(letter): 3-10
Medicare assignment; Patient handouts available on: 1-40
—assignment sign-up reaches 36% of MDs and DOs: 1-51
—participating physicians' directories available: 2-51
—regarding durable medical equipment; Recent changes in: 3-64
—changes due October 1: 8-23
—participating physician issue update: 9-39
—fee freeze: 9-39
—participating physician program clarified: 11-43
—My white hat (Falk)(editorial): 12-7
Medicine: Trade or profession? (Scott)(President's Page): 12-5
Medigap hotline: 1-800/242-1060: 6-147
Mental commitment standard; SMS physicians testify for additional: 10-47
Milwaukee brace (Gaenslen)(letters): 12-8
Minor's consent: 6-78
MRI; See under Magnetic resonance imaging

MEDICOLEGAL / SOCIOECONOMIC / ANCILLARY *continued*

Narcotics: 6-97
Newborn infant eye drops: 6-78
News you can use: 1-68, 2-84, 3-64, 4-79, 5-57, 7-128, 8-50, 9-54, 10-58, 11-56, 12-72
Nicaragua—diversified views (Madiedo)(letters): 4-9
—Press release (Keane, et al)(letters): 4-9
—(Dibbell)(letters): 4-10
—(Peters)(letters): 4-10
Nuclear war; Health consequences of: 8-23

Opening a physician's practice; Some considerations before: 6-92
Opportunities; Physician service, overseas: 11-56
Organ procurement system; Committee seeks ways to improve: 1-48
Organs; Donation of body: 6-75
—Uniform organ donor cards and decals: 6-75
—Donation of eyes: 6-75
—"Living will" on use of measures to sustain life: 6-75

Patient care; The patient is our first consideration (Flaherty)(President's Page) 1-4
—Maximum care at minimum cost (Scott)(President's Page): 8-5
Patients Compensation Fund; WHCLIP Fund rate increases recommended: 2-51
—The public, malpractice, the Wisconsin Patients Compensation Fund, and us (Sautter)(letter): 6-14
Peer review; Legal aspects of (Schmidt): 6-41
—in Wisconsin: 6-43
—Services; Mediation and: 6-47
—SMS Secretary issues call for tougher: 6-154
—Medical staffs and (Sivertson)(letter): 3-10
—proposal; Malpractice committee backs SMS: 2-51
—SMS testifies on peer review legislation: 4-48
Physical therapy relating to practice: 6-79
—practice without referral; Hearing held on: 10-44
—New drugless healers? (La Joie)(letters): 12-7
—Med student offers perspective on physical therapy (Muir)(letters): 12-8
Physician-patient-hospital relationship; Legal responsibilities of the: 6-60
Physician reimbursement; DHSS proposes 3.5% increase in: 1-51
Physician service opportunities overseas: 11-56
Physician's assistants (PAs): 6-79
Poison control program network; Wisconsin: 6-53
—warning stickers may not work: 1-14
Policy statement for alcohol abuse education in school; Pediatricians establish: 3-18
PPA census; All physicians! Plan to participate in the: 4-79
Practice; Some considerations before opening a physician's: 6-92
—Some considerations in the closing of a physician's: 6-93
—Closing a physician's office: 6-74
—management study courses offered: 3-64
Premarital examinations: 6-79
Profession?; Medicine: Trade or (Scott)(President's Page): 12-5
Psychiatric conference: 8-23
Public health; New Baby Doe rules proposed: 2-68
—SMS seeking repeal of rule allowing chiropractors to draw blood: 2-68
—Wisconsin and Soviet physicians meet in Chicago: 4-46
—Statewide network set up for AIDS testing: 8-27
—Traveler's diarrhea: 11-44

Quack cures: 11-56

Radiation accident victims concerns SMS EOH Committee; Hospital preparedness in treating: 1-48
Records; Retention and inspection of patients': 6-62, 6-78
—Consent to release medical information: 6-68
—Patients' right of access to their medical: 6-68, 7-79
—Denial of researcher access to health care: 6-69
—Denial of government access to health care: 6-69
—laws; Questions about medical: 6-70
—under law; Employees allowed to inspect: 6-76
—"Denial of access" to healthcare: 6-74
—DES-exposure information; Suggested patient form for obtaining: 3-17
Regulation; Welcome to Wisconsin (Flaherty)(President's Page): 3-5
—Joint Finance Committee considers healthcare regs: 4-49
—Saving more money in MoTown (Falk)(editorial): 10-6
Regulation and Licensing, Department of: 6-146
—Bureau of Health Professions: 6-146
—Medical Examining Board: 6-146
—Dentistry Examining Board: 6-146
—Pharmacy Examining Board: 6-146
—Bureau of Nursing: 6-146
—Board of Nursing: 6-146
Reimbursement; DHSS proposes 3.5% increase in physician: 1-51
—The case mix index (Boulanger)(editorial): 6-8
Relationship; Physician-patient-hospital, Legal responsibilities of the: 6-60
Report?; Must a Wisconsin physician: 6-90
Required request: A practical proposal for increasing the supply of cadaver organs for transplantation (Peters): 12-10
Retarded, developmentally disabled person; Helping the: 6-30
Return-to-work recommendations record; Attending physician's: 6-98
—form: 6-99
Rural health caucus; Senate: 8-50
RX for a busy physician (Scott)(President's Page): 10-5

School health; Pediatricians establish policy statement for alcohol abuse education in school: 3-18
Screening; Elevated blood pressure (Falk)(editorial): 1-7
Senate Bill 328; Ten statewide press conferences in two days: 11-42
ShareCare; Reform malpractice system to cut costs, Medical Society tells Legislature: 2-50
—The patient is our first consideration (Flaherty)(President's Page): 1-4
Smoking; Cigarettes fire-death hazard in hospital: 1-20
—Is your hospital in compliance? (Lindesmith)(letters): 4-11
Social Security Administration disability programs; Documentation needs of the (Handy): 1-16
Socioeconomic Monitoring System: 12-66
Specialty societies: 1-59, 8-34, 11-49, 6-133
—Wisconsin Chapter of American College of Physicians: 1-59, 8-34
—Wisconsin Academy of Family Physicians: 8-34
—American Society of Surgery of the Hand: 8-34
—Society of Thoracic Radiology: 8-34
—American Academy of Dermatology: 8-34
—American College of Utilization Review Physicians: 8-34
—Presidents and secretaries, Wisconsin Specialty Societies as of record June 1, 1985: 6-133
—American Congress of Rehabilitation Medicine: 11-49
—American College of Radiology: 11-49
—American College of Physicians: 11-49
—Wisconsin Society of Internal Medicine: 11-49
—Council of the American College of Surgeons, Wisconsin Chapter: 11-49
—Milwaukee Ophthalmological Society: 11-49
Surgical centers; Hospitals, surgeons, and free-standing (Boulanger)(editorial): 9-9

MEDICOLEGAL/SOCIOECONOMIC/ANCILLARY *continued*

Tax reform plan; President Reagan's: 10-58
Toxic substances and infectious agents; Important notice to physicians and clinics re: 6-96

Unemployed; Reform malpractice system to cut costs, Medical Society tells Legislature: 2-50
Uninsured; Uncompensated care problem looms on horizon, SMS President says: 2-50
Unprofessional conduct defined; Medical Examining Board, Chapter Med 10: 6-91
—definition; Changes made in: 10-58

Vocational Rehabilitation, Division of: 6-145
—Bureaus: 6-145
—Field offices: 6-145
Volunteer relief activities in Mexico City: 11-56

WHCLIP rate may increase 75%: 1-51
—Fund rate increases recommended: 2-51
—Malpractice committee backs SMS peer review proposal: 2-51
(WHO), Wisconsin Homecare Organization: 6-184
Widow/er; Problems of a physician's: 6-94
WiPRO; In search of accuracy (Boulanger)(editorial): 1-6
—The computer says (Falk)(editorial): 4-7
—What next? (Falk)(editorial): 8-6
—Time's-a-wastin' (Falk)(editorial) 6-8
—Wisconsin Peer Review Organization: 6-149
—Board of Directors: 6-149
—Regions: 6-149
WISPAC membership shows 50% increase: 1-51
—What is WISPAC?: 2-53
—A brief profile of the 1985 Wisconsin State Legislature: 4-50
—Some basic rules to follow when writing to your legislator: 5-43
—AMPAC leader reports: 9-40
—Needs your support: 9-54

STATE MEDICAL SOCIETY / ORGANIZATIONAL

Advertising: See Wisconsin Medical Journal
AMA House of Delegates Meeting, Dec 2-5, Highlights: 1-37
—Delegates and alternate delegates, SMS: List of officers and directors and: 3-44
AMA Physician Recognition Award recipients:
—December 1984: 2-54
—January 1985: 4-29
—February 1985: 4-30
—March 1985: 5-6
—April 1985; May 1985: 8-26
—June 1985; July 1985: 9-46
—August 1985; September 1985: 11-46
—October 1985: 12-15
Annual Meeting; Annual Meeting resolution deadline: 1-40
—SMS Annual Meeting approaching: 2-39
—Nominees for SMS offices; election April 26: 2-40
—H/D 1984-85 Nominating Committee: 2-42
—SMS needs MDs for committees, commissions: 2-43
—resolution deadline: 2-52
—Mark your calendar for SMS Annual Meeting April 25-27 in La Crosse: 3-40
—SMS of Wisconsin Program Schedule—A/M Apr 25-26-27, 1985, La Crosse: 3-42
—H/D: 1985 SMS of Wisconsin (list of delegates and alternates by district & sections): 3-44
—SMS A/M focuses on critical medical issues: 4-23
—Professional liability, emergency medical services, and government regulations are key issues for '85 House of Delegates: 4-24
—Summary report of SMS H/D April 25-26, 1985, La Crosse, Wisconsin: 6-158
—H/D Nominating Committee 1985-86: 6-163
—Attendance: 1064: 6-163
—Picture, New Fifty-Year Club members, 1985: 6-172
—Nominations sought for SMS offices: 9-32
—SMS Annual Meeting plans underway: 11-21
—resolution deadline: 12-34
AODA scheduled, Citizens' conference on: 8-24
Auxiliary: 1985-1986, SMS: 6-120
Awards; Medical School deans receive Directors Award: 6-166
—Outstanding medical students receive Houghton Award: 6-166
—Interstate Teaching Award goes to Doctor Sandmire: 6-168
—Maryland physician recipient of Beaumont Award: 6-169
—Doctor Jowsey delivers Elvehjem Lecture: 6-169
—Scientific Exhibit Awards: 6-170
—The "Beaumont 500" Club: 6-170
—Joan Pyre receives Presidential Citation: 6-170
—WRRC received Special Recognition Award: 6-168

Beaumont Award, Maryland physician recipient of: 6-169
"Beaumont 500," Club, The: 6-170
"Blue Book" 1985, *Wisconsin Medical Journal:* 6-23
—Update: 7-121, 8-26, 9-34, 11-44, 12-50
Board of Directors 1985-86: 6-120
—April Meeting highlights: 6-154
—SMS Board encourages negotiation in ER services: 9-27
—SMS Board reaffirms its position: Don't drop CME requirement: 3-39
—SMS June 29 Board meeting results: 8-23
Bookshelf: 1-64, 8-49, 11-55

Charitable, Educational and Scientific Foundation Contributions: 1-54, 2-54, 3-60, 4-42, 5-36, 6-114, 9-34, 10-44, 11-46, 12-66
—Dr Pomainville resigns CESF treasurer post: 4-23
—Annual Board meeting held: 9-32
—program and functions: 6-112
—Officers and Board of Trustees: 6-113
—student loan program, Facts . . . about the: 6-115
—"The Beaumont 500": 6-116, 6-117
Commissions And Committees: 1985-1986: 6-122
Communications, SMS launches campaign to improve: 4-30
Constitution And Bylaws of the State Medical Society of Wisconsin: 6-103
Continuing Medical Education meetings: 1-65, 2-82, 3-62, 4-77, 5-54, 6-188, 7-125, 8-47, 9-51, 10-55, 11-54
—CME credit deadline approaching: 11-56
—Accreditation Program: 6-100
—requirement, SMS Board reaffirms its position: Don't drop: 3-39
County Medical Societies: Presidents, Secretaries, and other officers: 2-44, 6-128, 7-115
County Societies, 1-53, 2-77, 3-46, 5-38, 8-33, 11-50, 12-48
—Adams/Marquette/Columbia: 11-50
—Brown: 2-77, 2-78, 3-46, 11-50
—Clark: 5-38
—Dane: 3-46
—Eau Claire/Dunn/Pepin: 2-78
—Jefferson: 1-53, 2-78
—Kenosha: 1-53
—Lincoln: 1-53, 12-48

STATE MEDICAL SOCIETY/ORGANIZATIONAL *continued*

—Marinette/Florence: 2-78, 12-48
—Milwaukee: 1-53
—Monroe: 2-78
—Outagamie: 2-78, 8-33, 12-48
—Sauk: 5-38
—Sheboygan: 3-46, 12-48
—Winnebago: 2-78, 5-38, 8-33, 11-50, 12-48
Court halts attempt to get SMS records: 4-31

Directors Award, Medical School deans receive: 6-166
Directors: 1985-1986, Officers and: 6-119
—Pictures: 6-121
—Map of Districts: 6-118
—Committees: 1985-86: 6-120
Dues due by May 15, SMS: 3-46

Editorials: 1-6, 2-6, 3-6, 4-6, 5-5, 6-8, 7-8, 7-5, 8-6, 9-9, 10-6, 11-6
—In search of accuracy (Boulanger): 1-6
—Social Security Disability Insurance Program in Wisconsin (Falk): 1-6
—Three thousand surgeries (Falk): 1-7
—Farewell (Falk): 1-7
—Elevated blood pressure (Falk): 1-7
—Malpractice panels: Are they the solution? (Boulanger): 2-6
—Malpractice panels: The Society's view (Johnson): 2-8
—DES—Forty years of fallout: 2-8
—The spittoon bowl (McCormick): 2-9
—I am sorry, Doctor (Falk): 2-9
—Advertising (Falk): 2-8
—Dying with your "rights on" or . . . killing with your "rights on" (Sautter): 3-6
—Appropriate disposition (Falk): 3-7
—Product liability laws (Falk): 3-7
—Doctors' draft (Falk): 3-8
—Futility (Falk): 3-8
—Fresh frozen plasma (Falk): 3-9
—$2,500 per day (Falk): 3-9
—Save a child—save the world: 4-6
—MRI (Falk): 4-7
—The computer says (Falk): 4-7
—Too late (Falk): 5-5
—Some thoughts about "The Fund" (Boulanger): 5-5
—The case mix index (Boulanger): 6-8
—Changing of the guard (Falk): 6-8
—Time's-a-wastin' (Falk): 6-9
—It's confusing (Falk): 7-5
—Madison medicine (Manhart): 7-5
—What next? (Falk): 8-6
—Skulduggery in the Senate (Falk): 8-6
—. . . "that made Milwaukee famous" (Falk): 8-7
—Hospitals, surgeons, and free-standing surgical centers (Boulanger): 9-9
—Saving more in MoTown (Falk): 10-6
—Irradiated foods (Falk): 10-6
—Gratifying response (Falk): 11-6
—It made me sick (Falk): 11-6
—Never, never, never (Falk): 11-6
—Noble work recognized: 11-6
—Non-nurse midwives (Falk): 11-6
—Telling testimony: 12-6
—Long-wear contact lenses (Falk): 12-6
—My white hat (Falk): 12-7
Elvehjem Lecture, Doctor Jowsey delivers: 6-169
Expense Reimbursement policy and procedure for physicians on State Medical Society business: 6-109

Fifty-Year Club members, New: 6-172
Financial Statements on the State Medical Society of Wisconsin: 6-165
Flaherty, Timothy S; Report to H/D as past president: "Our number one priority is malpractice reform": 6-177
Foundation: See Charitable, Educational and Scientific

Geneva, Declaration of: 6-110
Goodwin Physician-Citizen of the Year, Max: 12-34

Houghton Award, Outstanding medical students receive: 6-166
House of Delegates; 1985 SMS members, List of: 3-44
—Election results: 6-152
—April 25, 1985 highlights: 6-155
—Summary report of SMS H/D April 25-26, 1985, La Crosse, Wisconsin: 6-158
—Nominating Committee: 6-163
—Attendance: 1064: 6-163
—Thank you, Reference committees of H/D: 6-163
—Report to H/D as president: A full and promising agenda already laid out (Scott): 6-174
—Report to H/D as past president: "Our number one priority is malpractice reform" (Flaherty): 6-177
—Secretary's report to the H/D—"The problem of competence or incompetence" (Thayer): 6-181
—H/D Nominating Committee selects slate of candidates: 12-31

Interstate Teaching Award goes to Doctor Sandmire: 6-168

Kane, Mary A, New communications coordinator named: 11-21

Landis nominated for President-elect of SMS, Doctor: 1-44
—elected president-elect, Doctor: 5-28
—President-elect, Doctor Charles Landis, Milwaukee: 6-153
—President-elect Landis will not serve office: 12-31
Leadership Conference October 26 in Appleton, SMS: 9-28
—1985 Leadership Conference participants: 12-32
—Governor Earl addresses SMS Leadership Conference: 12-33

Medical Care to meet March 22; SMS Task Force on: 3-41
—picture SMS Task Force: 6-173
Medical Museum season began May 1: 6-156
—Doctor Pomainville honored: 8-25
Medical Yellow Pages: 1-61, 2-79, 3-59, 4-74, 5-52, 6-185, 7-123, 8-45, 9-49, 10-53, 11-51, 12-67
Membership; Directory-Update: 1-44, 2-47, 4-32, 5-29, 10-32, 11-30, 12-37
—facts: 1-52, 4-34, 6-151, 7-118, 9-48, 10-31, 11-26
—State Medical Society of Wisconsin Directory: 1985: 7-17
—Members want greater emphasis on public image of profession: 11-22
—Dues payment options available: 11-24
—Membership encouraged for residents and students: 11-24
—Reduced practice or retired membership classifications: 11-25
—Spouse physicians take note: 11-25
—SMS membership reaches new high: 12-31

News Highlights: 4-54, 5-37, 12-50

STATE MEDICAL SOCIETY / ORGANIZATIONAL *continued*

Oath of Hippocrates, The: 6-110
Obituaries: 1-60, 2-54, 4-66, 5-44, 8-35, 9-33, 10-48
—Andrew, Robert B, Madison: 1-60
—Bargholtz, William Ashland: 8-36
—Bergmann, Gerald J, Greenfield: 12-49
—Bickler, Edwin P, Wauwatosa: 5-44
—Biedlingmaier, Gerard J, Wauwatosa: 5-44
—Bonan, Joseph D, Wauwatosa: 5-44
—Burdette, Stella I, Amery: 5-44
—Burnett, Ralph George, Kenosha 2-54
—Callaghan, Desmond H, Hayward: 8-35
—Church, Ruth E, Whitewater (Waukesha): 10-48
—Clasen, Walter E, Wauwatosa: 4-68
—Cohen, Albert M, Fox Point (Milwaukee): 1-60
—Curtis, John Kimberly, Madison: 8-36
—Darby, Russell C, Oshkosh: 4-66
—Demeter, Nicholas D, Wauwatosa: 4-66
—Farnsworth, Richard W, Janesville: 5-44
—Foley, Charles Francis, Sparta: 10-48
—Frawley, Donald D, Sun City, Ariz (Milwaukee): 8-35
—Fruth, Rodney B, Elm Grove: 8-35
—Gehin, Francis E, Stevens Point: 10-48
—Gingrass, Rudolph P (Oconomowoc): 8-35
—Gonlag, Harry, Eau Claire: 4-67
—Gwinn, Rodney P, Sturgeon Bay: 8-35
—Hable, Albert P, Marshfield: 4-66
—Hatleberg, Earl A, Chippewa Falls: 9-33
—Haushalter, Lester E, Brookfield: 10-48
—Hutter, Adolph M Sr, Madison (Fond du Lac): 9-33
—Jarvis, Donald F, Tomahawk: 4-66
—Jensen, Richard E, Green Bay: 4-66
—Kennedy, Richard D, Eau Claire: 1-60
—Kult, Anthony S, Milwaukee: 12-49
—Lagman, Raul M, Cuba City: 2-54
—Ledbetter, Marion K, Tulsa, Okla (Madison): 9-33
—Limberg, Philip W, Glenwood City: 4-67
—Mason, Paul B, Sheboygan: 4-67
—McCaffrey, Maurice H, Denedin, Fla: 8-36
—McRoberts, Jerry W, Sheboygan: 4-68
—Midelfort, Christian Fredrik, La Crosse: 1-60
—Murphy, Raymond J, Green Bay: 10-48
—Najafzadeh, Moktar, Miami, Florida (Twin Lakes): 12-49
—Owen, George Colville, Milwaukee: 12-49
—Patterson, Lawrence G, Sun Lakes, Ariz (Waupaca): 9-33
—Peters, Bruno J, Wauwatosa: 8-36
—Rauch, Alphonsus M, West Bend (Kenosha and Lake Geneva): 1-60
—Ries, Michael F, Brownsville: 8-35
—Rose, Harold D, Wood: 2-54
—Rutledge, Paul E, Washington Island: 8-36
—Smith, Richard B, Brookfield: 9-33
—Stiennon, Oscar A, Green Bay: 2-54
—Studley, William H, Shorewood: 4-66
—Trimborn, Bernard Anthony, Milwaukee: 2-54
—Urdan, Benjamin E, Milwaukee: 12-49
—Vernetti, Lucy A, Phoenix, Ariz (Hurley): 10-48
—Yost, Raymond G, Manitowoc: 9-33
—Young, William N, Milwaukee: 4-66
—Wagner, Harold, Kenosha: 9-33
—Zeratsky, James D, Marinette: 12-49

Past Presidents of the State Medical Society of Wisconsin: 1961-1985: 6-120
Physician Briefs: 1-54, 4-51, 5-35, 8-29, 9-43, 10-49, 11-45, 12-51
Physician-citizen of the Year, Max Goodwin: 12-34
Physicians Alliance districts and field consultants, 1985: 6-126, 9-41, 10-45
Placement Service aids physicians and communities, SMS: 6-118
Pomainville honored at Medical Museum, Doctor: 8-25
President's Page: 1-4, 2-5, 3-5, 4-5, 5-28, 8-5, 9-5, 10-5, 11-5, 12-5
—The patient is our first consideration (Flaherty): 1-4
—Malpractice seizures (Flaherty): 2-5
—Welcome to Wisconsin regulation (Flaherty): 3-5
—What are you going to do for me in the future? (Flaherty): 4-5
—The new president, John K Scott, MD: 5-28
—The urge to merge (Scott): 7-4
—Maximum care at minimum cost (Scott): 8-5
—When the penalty tax comes due (Scott): 9-5
—RX for a busy physician (Scott): 10-5
—SB 328 and medical malpractice (Scott): 11-5
—Medicine: Trade or profession? (Scott): 12-5
Presidential Citation awarded to Joan Pyre: 6-170
Pyre, Joan; Presidential Citation awarded to: 6-170

Scientific Exhibit Awards: 6-170
Scott, MD, The new president—John K: 5-28
—Installed SMS president, Doctor Scott: 6-152
—Report to H/D as president: A full and promising agenda already laid out: 6-174
Senior physicians met November 9, Wisconsin Association: 11-25
—elect: 12-34
SMS helps sponsor sexual abuse workshop: 9-30
—hosts Soviet physicians at reception: 10-30
SMS Services Inc: 1985: 6-120
—Board highlights: 9-27
—endorses WC program: 9-28
Specialty Sections, Officers of SMS: 6-131

Thayer, Earl R; Secretary's report to the H/D—"The problem of competence or incompetence": 6-181
Treffert named to statewide professional discipline task force, Dr: 12-33

WASP met November 9: 11-25
Weinshel, Leo R, MD, named 1985 "Physician Citizen of the Year," Milwaukee's: 1-39
Wisconsin Medical Journal: index to advertisers: 1-64, 2-83, 3-61, 4-76, 5-56, 6-180, 7-127, 8-49, 9-53, 10-56, 11-55, 12-71
—Publication information: 1-10, 4-56, 5-56, 6-18
—Principles of advertising: 6-18
—New Editorial Board member: 6-154
—Statement of Ownership, Management and Circulation of the *Wisconsin Medical Journal*: 11-28
—Index to Volume 84, January 1985 through December 1986: 12-57
Wisconsin Rural Rehabilitation Corporation (WRRC) received Special Recognition Award: 6-168
WISPAC: AMPAC leader reports (Treacy): 9-40
—WISPAC Committee: 6-127
—WISPAC needs your support: 9-54
Workshop on Health, More than 1,000 students, teachers attend SMS: 11-21■

PHYSICIANS APPEAR TO BE spending more time with individual patients, the Socioeconomic Monitoring System of the AMA Center for Health Policy Research reported. The AMA's 1985 core survey found that physicians are devoting as much time in patient care this year as they were in 1984—about 51 hours per week—even though they are seeing slightly fewer patients. Last year's 2.5% decline in weekly patient visits per physician continues an 11-year trend toward smaller patient loads. Patient loads have been decreasing steadily since 1975 as more physicians enter the medical profession. Today's typical physician reports about 117.5 visits with patients each week. The 1985 survey of 4,040 nonfederal patient care physicians also showed that the average physician spent 7.1% fewer hours on hospital rounds, while hours for office visits increased only slightly (1.6%) during the first half of 1985 when compared with the first half of 1984. The decrease in physician hours spent on hospital rounds, coupled with only a slight increase in office visits, implies that physicians are working more in emergency rooms, outpatient clinics, and other nonoffice settings, a Socioeconomic Monitoring System spokesman said.■

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of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of October 1985.

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Solo internist desiring general internist to help in rapidly growing practice. Located on shore of Lake Michigan in Michigan's Upper Peninsula. New 107-bed acute care hospital. Campus for Michigan State College of Human Medicine. Call or write Dennis Spender, MD, PC, 218 South 10th St, Escanaba, MI 49829; ph 906/786-1563. p12/85;ltfn/86

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DEADLINE: Copy must be received by the 15th of the month preceding month of issue; e.g., copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Family practitioner. Seven-physician primary care group in Green Bay, Wisconsin needs one or two family practitioners to join growing practices. Salary commensurate with training and experience. Contact Kenneth J Hujet, MD, Dousman Clinic, Green Bay, Wis 54303; ph 414/494-9661. 12/85;1/86

South Central Minnesota Practice Association. Group Professional Corporation has opening for family practice occupational medicine. Service area of 65,000, fee for service; considering prepaid availability. Excellent benefits and earnings. Profit sharing and 401(K) plans. Fine residential living in outstanding small city of 20,000, ninety minutes from Minneapolis-St Paul. First class facilities and hospital, challenging medical practice. Contact: Albert Lea Regional Medical Group, PA, B J Boss, Associate Administrator or William Brouwer, Administrator, 1602 Fountain St, Albert Lea, MN 56007; ph 507/373-8251. 12/85;1/86

Family practitioner needed to join 11-physician expanding multispecialty practice in upper midwest. Board certified or eligible. Clinic adjoins JCAH hospital. Rural location with abundant outdoor recreational opportunities, small four-year college. Excellent salary and benefits. Call collect 715/532-6651 or send curriculum vitae with names of references to: Howard Chatterton, MD, 906 College Ave, West, Ladysmith, WI 54848. 12/85;1-2/86

Wisconsin, expanding and innovative group of residency-trained board certified emergency physicians is seeking ABEM certified/prepared emergency physicians for staff and administrative positions at Columbia Hospital in Milwaukee and Kenosha Memorial Hospital. Excellent patient populations, medical and administrative staffs, and medical school affiliation. Equity positions available. Send CV to: Thomas A Reminga, MD, Dept of Emergency Medicine, Columbia 2025 East Newport Ave, Milwaukee, WI 53211; ph 414/961-3508. 12/85;1-2/86

Growing multispecialty clinic is looking for two family practitioners. One to staff a three-person Walk-In Department and the other to function in a traditional family practice setting located in North Central Wisconsin. New facility situated across the street from new hospital. Full partnership in two years. Easy access to lakes, woods, and mountains. Write including CV to D K Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p11-12/85;1/86

Family Practitioner. River Valley Medical Center is seeking two family practice Board eligible/certified physicians for its multispecialty group of 16 physicians in Northwest Wisconsin. Excellent starting salary and comprehensive fringe benefit package the first year with full group membership after one year. Attached to a progressive 90-bed hospital. We are within 45 minutes of the St Paul-Minneapolis area. Please contact Dr Carl Hansen, Recruitment Chairman or Tom Halverson, Clinic Manager, 208 Adams St, South, St Croix Falls, WI 54024; ph 715/483-3221. p11/85;12tfn/85

Family Practice. Third family practice physician needed to join multispecialty group of 17 in Hartford, WI. Two branch locations. All facilities modern and well equipped. Guaranteed first year negotiable salary; usual fringe benefits. Contact: Murlin Bernd, Clinical Manager, 1004 E Sumner St, Hartford, WI 53027; ph 414/673-5745. 12/85;1/86

Wisconsin-Urgent Care Positions. Available on a part-time basis—weekends and weekdays for BC/BE family practitioners, internists. For more information contact Douglas Gremban, MD, St Elizabeth's First Care North, 1225 W Northland Ave, Appleton, WI 54914. Either send CV or telephone 414/738-2005. 12/85

Physician Preceptor in pediatrics. Upper Peninsula Health Education Corporation is accepting applications for a full-time Physician Preceptor in Pediatrics. Responsibilities include patient care and clinical instruction of medical students of Upper Peninsula branch campus of Michigan State University's College of Human Medicine. Requirements are board eligibility or certification in pediatrics with a commitment to medical education. Academic rank and salary commensurate with experience. Send inquiries to John Hickner, MD, Medical Director, Bay de Noc Family Health Center, Doctors Park, Escanaba, Mich 49829; ph 906/786-9510. 12/85

Wanted Board Certified Otolaryngologist. Head and neck surgeon. Join active one-man practice. General otolaryngology, head and neck surgery, facial plastic surgery, nasal allergy. Computerized office with x-ray, audiologist, and hearing aid dispensing. Northern Wisconsin near Apostle Islands National Lakeshore. Contact James A Hamp, MD, ENT Professional Associates, SC, 2101 Beaser Ave, Suite 1, Ashland, WI 54806; ph 715/682-9311. 10-12/85;1-3/86

PHYSICIANS EXCHANGE

continued

Women's OB/GYN Care, SC of Waukesha, Wisconsin, is seeking a BE/BC OB/GYN, including residents finishing '86-87, in a private, fee-for-services practice. This would add a *fifth* OB/GYN to our call schedule. Salary is negotiable with first year guarantee and early partnership. This 50,000 member community has solid support for patient centered OB/GYN care. Referrals from area general practitioners allow the OB/GYN to spend the majority of time practicing the specialty. Our nurse practitioner provides excellent patient education and preventive self-care. Our hospital is a Level #2 Obstetric facility with excellent pediatric colleagues, three of whom have neonatal experience. Wisconsin provides a myriad of outdoor and recreational activities and Milwaukee cultural events are only ½ hour away. Send CV to Dr Anne Riendl, PO Box 1907, Waukesha, WI 53187-1907; ph 414/544-2801. 11-12/85

Family Practitioner wanted to share existing practice and fully-equipped medical office in Waushara County. Salary plus incentives and opportunity for eventual purchase of practice. Excellent recreational area, a great place to live and raise a family. Send inquiries to Roy Grunwaldt, Administrator, Wild Rose Hospital, PO Box 243, Wild Rose, WI 54984; ph 414/622-3257, ext 212. p11-12/85;1-2/86

Family practice associate desired to join established Family Practice Group in central Indiana community of 50,000. Excellent facilities, comprehensive benefits, highly competitive earnings. Must be Board certified or eligible. Send curriculum vitae to: D Rogers, Business Manager, Kokomo Family Care, Inc, 806 South Berkley Rd, Kokomo, Ind 46901; ph 317/457-8341. p12/85

FAMILY PRACTITIONERS
INTERNISTS, OB/GYN

The UW Office of Rural Health is seeking primary care specialists for more than 50 communities throughout Wisconsin. Opportunities are available throughout Wisconsin for Board certified physicians trained in US medical schools and residencies.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin
Department of Family Medicine
777 S Mills St, Madison, WI 53715
Phone 608/263-4095 7/85-6/86

Emergency physicians full or part-time. Positions available in a moderate volume emergency room in Beloit, Wis. Must have an active interest in community relations. ACLS required. ATLS desirable. If interested, contact John Maher, MD, Director, Emergency Department, Beloit Memorial Hospital, 1969 W Hart Rd, Beloit, WI 53511. 11-12/85

Family Practice: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary gaurantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Fifty-eight-year-old general practitioner seeking part or full-time work in outpatient medical practice. Considerable experience in student health work. Have Wisconsin license. Available reasonably soon. Interested in small communities. Contact Dept 571 in care of the Journal. p11-12/85

Ophthalmologist, subspecialty pediatrics or glaucoma helpful but not required, Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Must be willing to do general ophthalmology. Immediate drawing area 100,000 with unopposed subspecialty referral area much higher. Located on Lake Michigan with excellent recreational activities. Optometric support available. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Wisconsin: Pediatrician with subspecialty interest to join multispecialty clinic that includes general pediatricians, pediatric hematologist, oncologist and neonatologist in city of 150,000. Send CV to Dept 561 in care of the Journal. 8tfn/85

Progressive Multispecialty Clinic in Milwaukee requires physicians in the following specialties: Family Practice, Orthopedic consultation and evaluation, Internal Medicine/Cardiology, Surgery/Emergency Trauma. Modern self-contained clinic offers competitive salary and attractive benefits including malpractice insurance. These staff needs are IMMEDIATE. Please forward CV and references to Dept 574 in care of the Journal. 12/85;1/86

Ophthalmologist. Board certified/Board eligible, to join one other Board certified ophthalmologist in rapidly expanding 40-member multispecialty group with high level ophthalmic pathology. Immediate drawing area 100,000. Located on Lake Michigan with excellent recreational activities. First-year salary. Association after one year with income based solely on production with superb benefits package. Contact D K Aymond, MD, The Sheboygan Clinic, 1011 North 8 Street, Sheboygan, WI 53081; ph 414/457-4461. 9tfn/85

Pediatrics/Neonatology: Thirty-one physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits, and early ownership. Neonatology skills needed for Level II Nursery. Please send curriculum vitae to R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Family practice opportunity—very busy five-physician practice being covered by four physicians. Pleasant South Central Wisconsin community of 15,000; close to Milwaukee and Madison. Excellent recreational area. First-year guaranteed salary. Excellent benefits. Contact: C Burchardt, Medical Associates, 1200 N Center, Beaver Dam, WI 53916; ph 414/887-7101. 10tfn/85

Internist or Family Practitioner to join two Internists and General Surgeon in growing, established, Green Bay area practice. Send CV to John Brusky, MD, 1203 South Military Ave, Green Bay, WI 53404. 7tfn/84

Pediatrician. BC/BE to join busy four-member Pediatric Department within a 23-member multispecialty group. Excellent benefits and competitive salary. Call or write: W J Mommaerts, Administrator, West Side Clinic, sc, 1551 Dousman St, Green Bay, WI 54303; ph 414/494-5611. 10-12/85;1/86

Physicians needed full or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Psychiatrist wanted. Wisconsin licensed and Board certified or eligible psychiatrist, part-time (20-35 hours/week) at the Bureau of Social Security Disability Insurance in Madison. If interested, write or telephone Daniel Kahn, MD, PO Box 7623, Madison, WI 53707; ph 608/266-6608. 12/85;1/86

PHYSICIANS EXCHANGE

continued

Excellent opportunity for a Board certified or eligible internist to practice in conjunction with an 8-member Internal Medicine Department of a 26-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 6tfn/85

Family Practitioner needed to join two FPs at the Ellsworth, Wisconsin office of a progressive eleven-physician group. Liberal fringes and financial package. Forty miles from metropolitan Minneapolis/St Paul. Contact R M Hammer, MD, River Falls, WI 54022; ph 715/425-6701 or 612/436-8809. 4tfn/85

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

OB/GYN: BC/BE to join three OB-GYNs in 31-physician multispecialty group. Beautiful lakefront community of 90,000 located between Milwaukee and Chicago offers a wealth of cultural, educational, and recreational opportunities. Well-equipped clinic and two local hospitals; salary guarantee with incentive bonus; excellent fringe benefits and early partnership. Send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 9tfn/85

Primary care physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to: Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. 9-12/85

Family Practitioner needed to join established Family Practice group in East Central Wisconsin city of 50,000 on beautiful Lake Winnebago. Competitive salary, fringes, excellent recreation area. Send CV to MS Knier, MD, 555 S Washburn, Oshkosh, Wis 54901; 414/426-0265. 10tfn/84

Urgent care physician and internist. Opportunities available as clinic services expand. This 35-member multispecialty group, including 13 internists, is housed in a modern facility next to the 240-bed Mercy Hospital and has a drawing area of 100,000. Send CV with inquiry: Ernest C Deeds, MD, Box 551, Janesville, WI 53547. 12/85

Second Family Practitioner needed to staff a satellite of a 38-physician multispecialty group in Kiel, a beautiful small community in East Central Wisconsin. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8 St, Sheboygan, WI 53081; ph 414/457-4461. c2tfn/85

West Bend, Wisconsin, General Clinic, a (18) physician multispecialty group, is seeking physicians in the specialties of Internal Medicine, Family Practice, OB/GYN, and Pediatrics. First-year salary guaranteed. Corporate membership possible after one year. Excellent fringe benefits. Located in scenic, recreational area with close proximity to Milwaukee. Please contact Hans W Schmelzling, Administrator, General Clinic, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 6tfn/85

ORTHOPEDIC SURGEON

Mid-Michigan community seeks orthopedic surgeon for service area of 90,000. Guaranteed first year income $150,000. Office space available in medical office building adjacent to the hospital. 214-bed hospital provides excellent diagnostic capabilities and new surgical facilities. Excellent opportunity for a physician seeking busy private practice opportunity with guaranteed success. Contact Vice President of Professional Service—517/723-5211, ext 1823.

p11-12/85;1-2/86

PHYSICIANS EXCHANGE

continued

Versatile Surgeon wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E Johnson, Ely Medical Center, Ltd, 224 East Chapman Street, Ely, Mn 55731; ph 218/365-3151. 6tfn/85

Family Practice physician, BE/BC, to share fully equipped medical office in southeast Wisconsin with busy Board certified family practitioner. Opportunity for partnership. Near Milwaukee and Chicago, rural atmosphere. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to F M Zarbock, MD, Box 158, S89 W22915 Maple Ave, Big Bend, WI 53103. 11-12/85;1/86

MEDICAL FACILITIES

General and surgical solo practice for sale. Gross in excess of $300,000. Growing desirable midwestern university city with population 25,000. One very well-equipped hospital in county of 60,000 a few blocks away. Owner will remain to introduce. Contact Dept 563 in care of the Journal. 9tfn/85

MISCELLANEOUS

Physicians Signature Loans to $50,000. Up to 7 years to repay. Competitive fixed rate, with no points, fees, or charges of any kind. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800)241-6905. 10eom/83

HOLTER MONITOR

Quality Scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretations, scan price $35.00 with UPS speedy delivery. Recorders loaned, leased, or purchase new dual-channel Holter recorders, $1295.00, with one-year warranty. For more information call Advance Medical and Research Center 1-800/552-6753. 11tfn/85

We buy/sell/lease and service new and reconditioned Holter-Stress-Echo-EKG and other Medical Electronic Instruments. Contact Ed Bentolila, New Life Systems, Inc, PO Box 8767, Coral Springs, FL 33065; ph 305/972-4600. 12/85;1-2/86

For sale: Going out of business; will sell Gemstar Chemical Analyzer and Circadian Holter Monitor. Ph 515/484-4953. 12/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

JANUARY 19–22, 1986: *New Therapeutics VI: The Results of Recent Advances in Medicine.* Telemark Lodge, Cable, Wis. Sponsored by University of Wisconsin School of Medicine and Continuing Medical Education. AMA Category I credit 14 hours, Family Practice credit pending, University of Wisconsin CEUs 1.4. Contact: Ann Bailey, Continuing Medical Education, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53705; ph 608/263-2854. 11-12/85

MARCH 6–7, 1986: *Symposium on Chronic Obstructive Pulmonary Disease.* The Sheraton Inn, Madison. Sponsored by Continuing Medical Education, School of Medicine, University of Wisconsin-Madison; Pulmonary Section, Department of Medicine, School of Medicine, University of Wisconsin-Madison; and Departments of Nursing and Respiratory Therapy, Clinical Science Center, University of Wisconsin-Madison. AMA Category I credit and University of Wisconsin CEUs—both approximately 14 hours. Contact: Sarah Aslakson, Continuing Medical Education, 610 Walnut St, 465B WARF Bldg, Madison, WI 53705; ph 608/263-2856. 12/85

APRIL 11–12, 1986: Wisconsin Urological Society, Edgewater Hotel, Madison. g11-12/85;1-3/86

MAY 30–31, 1986: Wisconsin Radiological Society, American Club, Kohler. g12/85;1-4/86

JUNE 11–14, 1986: Wisconsin Academy of Family Physicians, Telemark Lodge, Cable. g11-12/85;1-5/86

JULY 17–19, 1986: Wisconsin Society of Obstetrics & Gynecology, Embassy Suites, Green Bay. g11-12/85;1-6/86

AUGUST 1–3, 1986: Wisconsin Dermatological Society, The Abbey, Lake Geneva. g11-12/85;1-7/86

SEPTEMBER 5–7, 1986: Wisconsin Anesthesiologists, The Abbey, Lake Geneva. g12/85;1-8/86

Wisconsin Specialty Society Meetings 1986

- Wisconsin Urological Society, Apr 11-12, 1986, Edgewater Hotel, Madison
- Wisconsin Radiological Society, May 30-31, 1986, American Club, Kohler
- Wisconsin Society of Anesthesiologists, Sept 5-7, 1986, The Abbey, Lake Geneva
- Wisconsin Academy of Family Physicians, June 11-14, 1986, Telemark Lodge, Cable
- Wisconsin Society of Obstetrics & Gynecology, July 17-19, 1986, Embassy Suites, Green Bay
- Wisconsin Dermatological Society, Aug 1-3, 1986, The Abbey, Lake Geneva
- Wisconsin Society of Internal Medicine, Sept 11-13, 1986, The Edgewater Hotel, Madison
- Wisconsin Radiological Society, Oct 3-4, 1986, The Concourse Hotel, Madison

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing.

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE tor listings is 15th of the month preceding the month of publication; e.g., copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

FOR LISTING of other meetings see the January 4, 1985 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period January 1985 through December 1985.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

SEPTEMBER 11–13, 1986: Wisconsin Society of Internal Medicine, The Edgewater Hotel, Madison. g12/85;1-8/86

OCTOBER 3–4, 1986: Wisconsin Radiological Society, The Concourse Hotel, Madison. g12/85;1-9/86

OTHERS

JANUARY–JULY 1986: (Minnesota): *Continuing medical education programs,* University of Minnesota Medical School, Minneapolis. See details in full-page ad elsewhere in this issue. g10/85

FEBRUARY 13-14, 1986 (Michigan): *Tenth Annual Winter Pediatric Conference* at Powderhorn Ski Area, Ironwood, Michigan. Guest speaker is James A Stockman, III, MD. Info: Marshfield Medical Education Department or H James Nickerson, MD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wisconsin 54449. 9-12/85; 1-86

1986 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS— Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-12 days year-round. Approved for 20-24 CME Category 1 credits (AMA/PRA) & AAFP prescribed credits. Distinguished professors. FLY ROUND—TRIP FREE ON CARIBBEAN, MEXICAN, & ALASKAN CRUISES. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 516/549-0869. p10-12/85

WEEKLY SEMINARS

Most major ski areas, Club Med, Disney World, Cruising aboard Sailboats in the Virgin Islands or a Mississippi Paddlewheeler. Topic: ***Medical-legal issues.*** Accredited Category 2 by AMA.

Current Concept Seminars, Inc (since 1980). 3301 Johnson St, Hollywood, FL 33021; ph 800/428-6069. $175. p9-12/85; 1-2/86

APRIL 10–13, 1986 (California): American College of Physicians 67th Annual Session, San Francisco Moscone Center, San Francisco, Calif. g12/85;1-3/86

APRIL 11–13, 1986 (Illinois): AMA's Seventh National Conference on the Impaired Physician, Hilton Hotel and Towers, Chicago. (see further details in this section) g12/85;1-3/86

AMA

JUNE 21–25, 1987: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 6–9, 1987: Interim AMA House of Delegates, Atlanta, GA.

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX. ■

AMA's 7th National Conference on the Impaired Physician

IMPAIRMENT AND WELL-BEING OF HEALTH PROFESSIONALS: A FAMILY AFFAIR

April 11–13, 1986/Hilton Hotel and Towers, Chicago

Sponsored by AMA in cooperation with the American Central Association, American Medical Veterinary Association, American Nurses' Association, American Pharmaceutical Association, American Podiatric Medical Association, American Medical Womens Association and National Medical Association. The Illinois State Medical Society is acting as host.

The conference, which will focus not just on impaired physicians but also on allied health professionals, will serve as a forum for those involved with primary and/or secondary prevention and treatment of impairment. Attendees will be drawn from hospital administrators, licensing board personnel, school deans, residency training directors, spouses, and medical student leaders.

Info: Janice Robertson, Media Relations Department, 535 North Dearborn St, Chicago, IL 60601; ph 312/645-5079. g12/85;1-3/86

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State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1986–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel.

1986—April 17–19
1987—March 26–28
1988—April 28–30
1989—April 13–15
1990—April 26–28
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

HEALTH PROSPECTS 1983/2003 SURVEY REPORTED. The State Medical Society was one of 415 health system leaders who completed a survey conducted by the Project HOPE Center for Health Affairs to determine health prospects from 1983 to 2003. A report of the survey shows that respondents expected life-expectancy to increase 3.7 years by 2002. Health status was also expected to improve in the next 20 years, but less than it had in the past 20 years. Respondents expected continued growth in health expenditures, although increases were expected to moderate, especially from 1988-2002. Almost all respondents believed the public's greatest concern about personal health services had shifted from access in 1962 to cost in 1982. Two out of every five respondents said "cost" is the most important problem of the US health system today. Half of these respondents wanted to implement competition or cost-containment, or encourage alternative delivery systems; the remainder described other changes. Respondents' visions of the most significant change that would occur in the US health system in the next 20 years included: Improved lifestyles; the corporatization (sic) of healthcare; a national healthcare system; competition among providers; and advances in technology. Respondents were generally more optimistic about the system's long-term future (1988-2002) than about the outlook for the next five years. There appear to be no universally shared assumptions about the best way to improve health status or the efficiency of healthcare delivery, the report concluded. Physicians wishing a copy of the report may contact: Allen S Meyerhoff, Senior Policy Analyst, Project HOPE, Center for Health Affairs, Millwood, VA 22646 (ph 703/837-2100) or Peter G Goldschmidt, MD, Director, Policy Research Institute, 2500 Maryland Ave, Baltimore, MD 21218 (ph 301/889-3000).■

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS of the AMA is planning a national conference on medical ethics March 14-16, 1986 in New Orleans. The conference will be cosponsored by the Hastings Center, Hastings-on-Hudson, NY. For further information contact Mary Devlin, Medicolegal Affairs, AMA headquarters, Chicago. The telephone number is (312) 645-4613.■

JCAH ANNOUNCES NEW QUALITY REVIEW BULLETIN. The Joint Commission on Accreditation of Hospitals (JCAH) has announced publication of the new *Quality Review Bulletin* (QRB) special publication, *Quality of Care for the Terminally Ill: An Examination of the Issues.* A collection of articles written by noted authorities, this publication provides practical information about the various aspects involved in the care of terminally ill patients. Issues addressed include: quality assurance; law and ethics; financial, risk, and pain management; and psychosocial, spiritual, and bereavement care. This special publication can be ordered by sending $20 for each copy to: Cashier: JCAH, 875 North Michigan Ave, Chicago, IL 60611. For further information regarding this or any JCAH publication, telephone Customer Service at JCAH, 312/642-6061.■

AMA SAYS SUPREME COURT ACTION ON CALIFORNIA MALPRACTICE LAW IS 'SIGNIFICANT'. The United States' Supreme Court ruling October 18 to dismiss an appeal challenging the constitutionality of the 1975 California law establishing a $250,000 maximum limitation on noneconomic losses in medical liability suits is "significant," the AMA said in a national bulletin issued on the heels of the ruling. The 8-1 dismissal for lack of a "substantial federal question" was greeted as "a strong signal to the state legislatures and courts that they may place limits on court awards for both economic and noneconomic damages in professional liability cases." California and Indiana are the only two states which have upheld the constitutionality of liability "caps." The Supreme Court's lone dissenter, Justice Byron White, cautioned, however, that "whether due process requires a legislatively enacted compensation scheme to be a quid pro quo for the common law or state law remedy it replaces, and if so, how adequate it must be, . . . appears to be an issue unresolved by this court." Furthermore, White said, the issue is "one which is dividing the appellate and highest courts of several states. The issue is important, and is deserving of this Court's review. Moreover, given the continued national concern over the 'malpractice crisis' it is likely that more states will enact similar types of limitations and that the issue will recur."■

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

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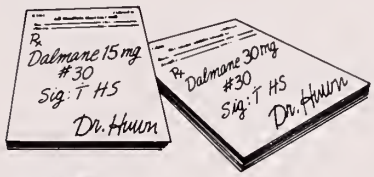
15-mg/30-mg capsules

References: 1. Koles J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978. **7.** Koles A, Koles JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennont FS, *et al:* Symposium on the Treotment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblott DJ, Allen MD, Shoder RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
flurozepom HCl/Roche Ⓡ

Before prescribing, pleose consult complete product infarmation, a summary of which follaws:

Indicotions: Effective in all types of insomnio chorocterized by difficulty in talling osleep, frequent nocturnal awokenings and/or early morning owakening. In patients with recurring insomnio or poor sleeping hobits, in ocute or chronic medical situations requiring restful sleep. Objective sleep loboratory doto have shown effectiveness for at least 28 consecutive nights of odministrotion. Since insomnio is offen tronsient and intermittent, prolonged odministrotion is generally not necessory or recommended. Repeated therapy should only be undertoken with oppropriote potient evaluation.

Controindicotions: Known hypersensitivity to flurozepom HCl; pregnoncy. Benzodiozepines moy couse fetol damoge when administered during pregnoncy. Several studies suggest on increased risk of congenital malformotions ossocioted with benzodiozepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurozepam. Instruct potients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Coution potients obout possible combined effects with alcohol ond other CNS depressonts. An additive effect moy occur if olcohol is consumed the doy following use for nighttime sedotion. This potentiol may exist for severol days following discontinuation. Caution agoinst hozardous occupations requiring complete mentol olertness (*e.g.*, operating mochinery, driving). Potentiol impairment of performance of such octivities moy occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrowal symptoms rarely reported, obrupt discontinuotion should be ovoided with groduol topering of dosage for those patients on medication for a prolonged period of time. Use coution in odministering to oddiction-prone individuols or those who might increose dosoge.

Precautions: In elderly ond debilitoted potients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedotion, dizziness, contusion ond/or otaxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed potients, or in those with latent depression or suicidal tendencies, or in those with impoired renol or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, stoggering, ataxia and folling have occurred, particularly in elderly or debilitated patients. Severe sedotion, lethorgy, disorientation and como, probably indicative of drug intolerance or overdosoge, have been reported. Also reported: heodoche, heartburn, upset stomach, nouseo, vomiting, diarrheo, constipotion, GI pain, nervousness, tolkativeness, opprehension, irritobility, weokness, polpitations, chest pains, body and joint poins ond GU complaints. There hove also been rore occurrences of leukopenia, gronulocytopenia, sweating, tlushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breoth, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, contusion, restlessness, hollucinotions, and elevoted SGOT, SGPT, totol ond direct bilirubins, ond olkaline phosphatase, and poradoxicol reactions, *e.g.* excitement, stimulotion ond hyperoctivity.

Dosage: Individualize for maximum beneficial effect. *Adults* 30 mg usuol dosoge, 15 mg moy suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules contoining 15 mg or 30 mg flurozepom HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

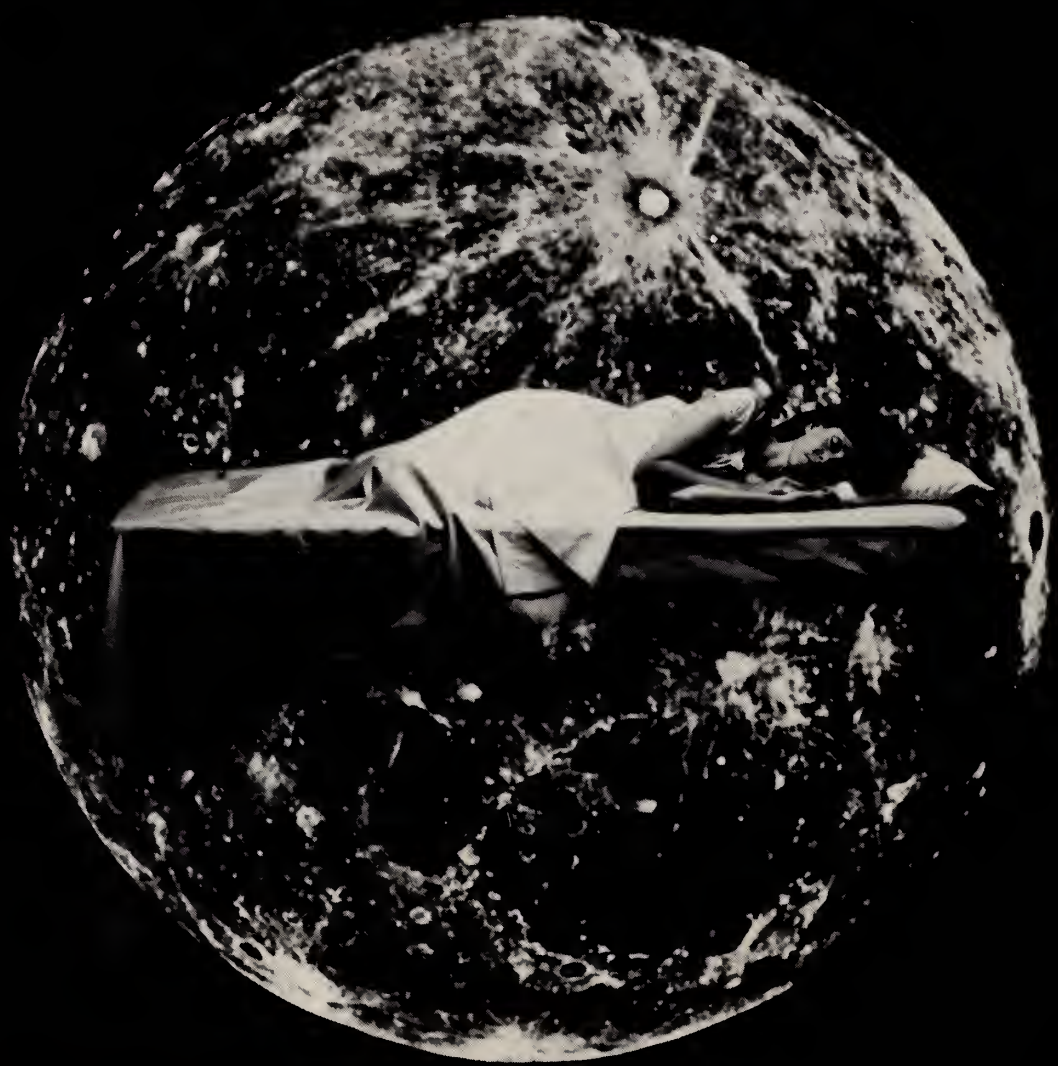
After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side

DALMANE®

flurazepam HCl/Roche ⓘⓥ

sleep that satisfies



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